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Inspector General
United States Department of Defense

Assessment of the U.S. Department of Defense Efforts to Develop an Effective Medical Logistics System within the Afghan National Security Forces

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INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
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June 14, 2011

MEMORANDUM FOR DISTRIBUTION

SUBJECT: Assessment of the U.S. Department of Defense Efforts to Develop an Effective Medical Logistics System within the Afghan National Security Forces (Project No. D2011-D00SPO-0092.000)

We are providing this final report for review and comment. We performed this assessment in response to a request from Commander, NATO Training Mission-Afghanistan (NTM-A)/Commander, Combined Security Transition Command-Afghanistan (CSTC-A). We considered client comments on a draft of this report when preparing the final report.

For purposes of this report, we request the following additional comments and information within 30 days of the report publication date or in the time frame as indicated in our response:

- NTM-A/CSTC-A – Recommendations 6a, 6c, 7, 8a, 8b, 8c, 11b, 13a, 13b, 14a, 14c, 19b, and 20.
- ISAF – Recommendations 17a.
- Under Secretary of Defense for Personnel and Readiness – 17b and 19a.

If possible, send your comments in electronic format (Adobe Acrobat file only) to SPO@dodig.mil. Copies of your comments must have the actual signature of the authorizing official for your organization. We are unable to accept the / Signed / symbol in place of the actual signature. If you arrange to send classified comments electronically, you must send them over the SECRET Internet Protocol Router Network (SIPRNET).

We appreciate the courtesies extended to our staff. Please direct questions to Mr. Phil VanLandingham at (703) 604-8948 (DSN 664-8948), joseph.vanlandingham@dodig.mil.

Kenneth P. Moorefield
Deputy Inspector

Executive Summary: Assessment of the U.S. Department of Defense Efforts to Develop an Effective Medical Logistics System within the Afghan National Security Forces

Who Should Read This Report?

Personnel within the Office of the Secretary of Defense, the Joint Staff, the U.S. Central Command and its subordinate commands in Afghanistan, the Military Departments, and Agencies that are responsible for and engaged in efforts to develop an effective Medical Logistics System in support of the Afghan National Security Forces (ANSF) should read this report.

Background

This assessment of the ANSF Medical Logistics System was conducted in response to a request received on November 10, 2010 from the Commander, NATO Training Mission-Afghanistan (NTM-A)/Commander, Combined Security Transition Command-Afghanistan (CSTC-A) that specifically asked the Department of Defense Deputy Inspector General (DODIG) Special Plans and Operations (SPO) to:

- "examine the systems in place for U.S. procurement and distribution, storage, accountability and use of pharmaceuticals for the Afghan National Army"
- "assess our advisory and oversight mechanisms of the NTM-A/CSTC-A Medical Training Advisory Group (MTAG) and Logistics Training Advisory Group in supporting this"

Throughout fieldwork, our assessment teams traveled throughout Afghanistan to visit medical facilities and warehouses, and interview ANSF medical personnel, ANSF medical logisticians, and their U.S. and Coalition Force mentors. Here a DODIG assessment team boards a Canadian military helicopter in Mazar-e-Sharif on December 5, 2010.

On November 28, 2010, assembled members from DODIG departed CONUS to commence fieldwork. The team conducted physical site visits and held interviews with ANSF and NTM-A/CSTC-A officials located in Kabul, Mazar-e-Sharif, Kandahar and Heart. Due to security considerations, the team interviewed NTM-A/CSTC-A medical mentors in Gardez by telephone.

On December 16, 2010, the SPO team provided the Commander NTM-A/CSTC-A Lieutenant General William B. Caldwell, USA and his staff an outbrief with preliminary observations resulting from the field work conducted.

In February 2011, in a subsequent engagement directed by the DODIG, SPO and OIG Audit personnel on the ground in Kabul conducted a walk-through and "quick look" review of apparent health care, sanitation, and inventory problems at the Afghan National Army (ANA) National Military Hospital (NMH). The team reported their results to the command and the DODIG. The command acknowledged identified shortcomings, qualified certain observations, and identified actions being taken to improve not only NMH conditions but also to address broader ANA health care system issues. Please see Appendix F for the reporting on the review referred to in this paragraph.

Development of the Afghan National Army (ANA) and Afghan National Police (ANP) Health Care System

The purpose of the ANA and ANP health care system is to provide health service support to Afghan Soldiers, Policemen and other beneficiaries of the ANSF. The ANSF medical units include:

- The ANA Surgeon General and staff, the ANA Medical Command consisting of the Dawood National Military Hospital and its supply depot, four regional hospitals and their supply depots, and the Armed Forces Academy of Medical Sciences.

National Military Hospital, Kabul, Afghanistan, December 2, 2010.

In addition, ANA Medical Staff at Corps and below Include Corps Surgeons, Garrison Clinics, Brigade Surgeons and staff, three battalion aid stations per combat brigade, one medical company and one medical platoon per Brigade Combat Service Support Battalion.

- The Afghan National Police (ANP) Surgeon General and staff, and medical assets which include the Office of the Surgeon General and subordinate administrative offices, Afghan National Police Hospital, training center clinics, and medics assigned to the border and civil order police.

For a more complete description of the ANA and ANP Health Care System as well as a map identifying facility locations, please refer to Appendix E of this report.

Results

The report is divided into three parts: (1) Planning and Execution; (2) Accountability and Control Mechanisms, and (3) Coalition Medical Mentoring Effort. The report makes 20 observations and 50 recommendations. The results are discussed therein.

Planning and Execution

There were 10 observations associated with planning and execution to develop a credible medical logistics system. The observations indicate that there was evidence of planning for the development of a medical logistics system, however execution had not matured.

Shortcomings in these significant areas of planning and execution indicated the ability of the ANA to build and maintain a sustainable medical logistics system at its current level of capability was not feasible in the absence of U.S. and International community support. Substantial systemic improvements are required before the ANA has and can operate with sustainability.

Accountability and Control Mechanisms

Under this heading, there were five observations associated with the adequacy of the medical logistics system regarding accountability and control mechanisms, including procedures for funding, acquisition, receipt, storage, accountability and distribution of Class VIII[1] consumables. While a system of controls existed for medical logistics, it is noted that the application of key elements was inadequate and as a result, accountability was weak.

Because ANSF medical officials and logisticians did not properly establish requirements for procurements, or manage or account for Class VIII inventory in accordance with MoD policy, the United States and its Coalition partners have been purchasing inventory that was not needed. In addition, Class VIII inventory (primarily pharmaceuticals) provided to the ANSF by the U.S. Government or other Coalition Forces was at significant risk of theft, misappropriation, or other illegal acts. Lastly, the medication needed by medical care providers has not been consistently supplied or provided at all.

Coalition Medical Mentoring Effort

There were five observations associated with the sufficiency of mentoring/advising efforts to develop an effective, sustainable medical system in the absence of established medical standards. It was clear that medical mentors and advisors were producing exemplary results working with

[1] Medical materiel, including equipment and supplies, is referred to as Class VIII; this designation is used throughout this report.

their Afghan counterparts in austere and challenging environments. However, pre-deployment preparation and sufficient in-country orientation and management for medical mentors were lacking and compounded by the fact that the medical mentoring staff was approximately half of the number NTM-A/CSTC-A planned for. Additionally, medical logistics mentoring has had limited success in enabling the ANA to develop credible Class VIII support for the ANA Health Care System.

Based on our assessment of the critical areas above, we determined that Medical Mentoring efforts are insufficiently effective in developing medical leadership or establishing enduring institutional capacity for an effective, Afghan-sustainable, ANA and ANP Health Care System (HCS)[2] that supports the Government of the Islamic Republic of Afghanistan (GIRoA) by enabling accountable Afghan-led security.

Subsequent Measures taken by International Security Assistance Force (ISAF) and NTM-A/CSTC-A

Subsequent to our field work in Afghanistan, NTM-A/CSTC-A has been moving proactively and aggressively to strengthen measures aimed at ensuring a successful ANSF transition. Ongoing actions include:

- Working with CURE International and the ANSF to complete, promulgate and implement the Standards of Care for the ANSF.
- Standing up an Operational Planning Team with the ANSF to establish performance milestones and decision points.
- Pursuing the appropriate numbers, skills, and seniority of mentors, as well as requesting appropriate pre-deployment training for medical mentors.
- ISAF engaged in delineating the division of responsibility for ANSF healthcare development between NTM-S/CSTC-A and IJC; above Corps is the responsibility of NTM-A/CSTC-A and Corps and below is the responsibility of IJC.

For detailed discussions of the foregoing observations and recommendations, please refer to the respective sections in the report.

[2] HCS is used to describe an ANA and ANP health care system that is the appropriate blend of the Force Health Protection and Combat Health Support system concepts found in existing and accepted military medicine doctrine.

Recommendations Table

Office of Primary Responsibility	Recommendations Requiring Additional Comment/Information	No Additional Comments Required at This Time
NATO Training Mission-Afghanistan (NTM-A)/Combined Security Transition Command-Afghanistan (CSTC-A)	6a, 6c, 7, 8a, 8b, 8c, 11b, 13a, 13b, 14a, 14c, 19b, 20	1, 2a, 2b, 2c, 2d, 3a, 3b, 4a, 4b, 4c, 5a, 5b, 5c, 5d, 6b, 6d, 9a, 9b, 10a, 10b, 11a, 12, 14b, 15a, 15b, 15c, 17c, 18b, 18c, 19c
International Security Assistance Force (ISAF)	17a	11b, 16, 17d, 18a, 18d, 20
Under Secretary of Defense for Personnel and Readiness (USD (P&R))	17b, 19a	

Please provide comments by July 14, 2011

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PART I – PLANNING AND EXECUTION

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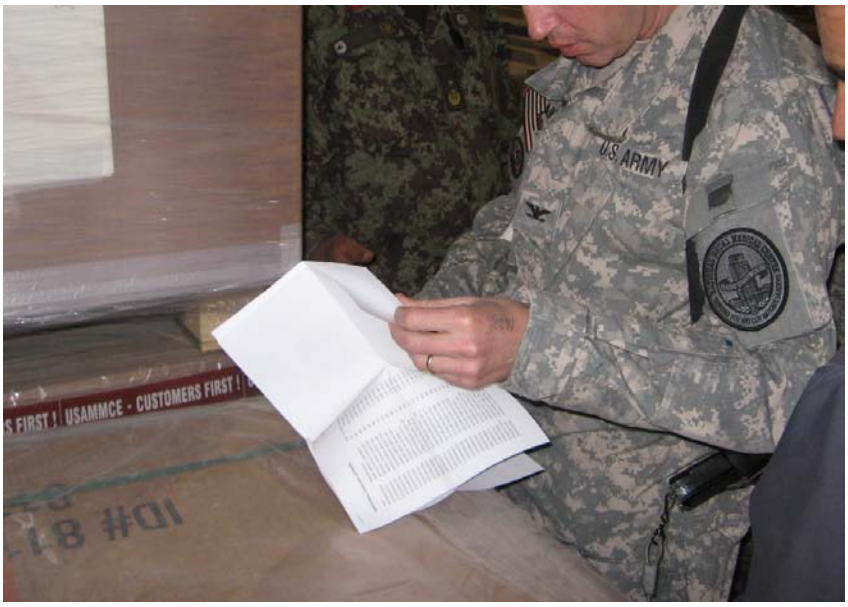
Planning and Execution

Background

A medical logistics system requires elements of planning which in turn allows for adequate execution of system processes and procedures in order to meet customer needs. Elements for both planning and execution should include, at a minimum:

- Forecasting of these needs for current and future requirements as they affect acquisition
- Input from customers on equipment and supply needs on a regular basis
- Recording and monitoring receipt, issuance, and on hand quantities in order to meet customer needs, forecast for emergency, indicate when re-ordering is necessary, or identify shortages that re-distribution of items can address
- Policies and procedures which incorporate these items and ensure uniform understanding and application by users



NTM-A/CSTC-A policy requires that all pharmaceuticals they provide to Afghan National Security Forces be procured through U.S. channels. Here a senior member of the DoDIG assessment team is tracking a U.S. shipment received from the U.S. Army Medical Materiel Center-Europe (USAMMCE), Pirmasens, Germany. Photograph taken during a site visit to the ANA Class VIII Warehouse, Kabul, Afghanistan, December 2, 2010.

What we did

Our assessment looked at the Afghan National Security Forces (ANSF) medical logistics system for these and related requirements through:

- Interviews with responsible U.S. officials in the NATO Training Mission-Afghanistan/Combined Security Transition Command-Afghanistan (NTM-A/CSTC-A), in particular members of the Medical Transition Assistance Group (MTAG)
- Interviews with senior Afghan officials in the Ministry of Defense (MoD), Ministry of Interior (MoI), and the Afghan National Army (ANA) and Afghan National Police (ANP) Surgeons General
- Site visits to ANSF hospitals, including the National Military Hospital (NMH) in Kabul; ANP Hospital (Kabul); and Regional Military Hospitals (RMHs) at Kandahar, Mazar-e-Sharif, and Heart
- Site visits to depots and warehouses including the National Military Depot (Kabul); ANP Warehouse (Kabul); Kabul Regional Military Depot; and Forward Supply Depots at Kandahar, Mazar-e-Sharif, and Herat

- Limited testing of items acquired through pseudo-Foreign Military Sales (hereafter FMS)[3] shipments and NTM-A/CSTC-A local contracting[4], reconciling quantity shipped with that received and on hand or issued to Afghan property records where possible (the results of this work are discussed in Part II, Accountability & Control)

What we found

An ANA medical logistics system exists but is currently not sufficient to meet the needs of the ANA and is not sustainable in the absence of significant continued U.S. and other foreign nation support. As discussed in more detail in each observation to follow, deficiencies occurred in the areas of:

Our assessment concluded that the Afghanistan National Army's medical logistics system is not currently sustainable without substantial continuing support from U.S. or other Coalition Forces. Here is an ANA Class VIII warehouse for pharmaceuticals, supplies, and equipment located on Camp Stone, near Herat, Afghanistan, December 11, 2010.

- FMS acquisition in terms of needs
- ANSF acquisition of Class VIII materiel
- Class VIII materiel under MoD logistics management
- Class VIII requirements capture
- Defined Authorized Stockage List
- Standardized list of medications and related consumable supplies
- Quality of Pharmaceuticals
- Vaccine supplies for ANA recruits
- Medical equipment maintenance
- Requisition procedures

Summary

Shortcomings in these significant areas of planning and execution indicate the ability of the ANA to build and maintain a sustainable medical logistics system at its current level of capability is not feasible in the absence of U.S. and International Community support. Substantial systemic improvements will be required before the ANA has the necessary capability and can operate with sustainability.

[3] Pseudo-FMS is the term used for acquisitions using standard security assistance procedures, but in the case of Afghanistan using Afghan Security Forces Fund (ASFF) appropriated monies rather than host nation funds or U.S.-provided grants. ASFF funds are provided through the annual DoD appropriations bill; hence, they are Title 10 as opposed to the standard Title 22 funds normally used for FMS sales and grant.

[4] Local contracting is performed through the Kabul Regional Contracting Center (KRCC).

Observation 1: Class VIII FMS and NTM-A / CSTC-A purchasing processes perpetuate dependence on a U.S. supply chain

The reliance upon U.S. funded and purchased Class VIII acquisition has done little to build organic ANA capacity to handle this responsibility and has perpetuated a reliance on the U.S. (as the predominant purchaser).

This incapacity has come about because the ANA HCS has been primarily supplied by three sources of supply and equipment: U.S. Title 10 FMS shipments, Kabul Regional Contracting Center (KRCC) contracts (generated through NTM-A/CSTC-A) and ANA-funded/ANA-processed contracts which represent a minority share of the procurements.[5] In addition, MoD Acquisition, Technology and Logistics (AT&L) does not have significant experience with medical acquisition, making it problematic for MoD Logistics Command (LOGCOM)[6] to fully inherit responsibility for 100% of the ANA's Class VIII requirements.

The ANA is thus currently incapable of autonomously performing this mission which has led to dependency on the U.S. military's procurement and acquisition systems and insufficiently developed ANA capability.

Applicable Criteria

"Report on Progress Toward Security and Stability in Afghanistan and United States Plan for Sustaining the Afghanistan National Security Forces – Report to Congress in accordance with sections 1230 and 1231 of the National Defense Authorization Act for Fiscal Year 2008 (Public Law 110-81)," April 2010 The document provides detail on the overall U.S. strategy for developing the Government of the Islamic Republic of Afghanistan (GIROA) and the ANSF, specifically "...the goal is to develop a self-reliant and professionally led ANSF with the ability to generate and sustain enduring capabilities through enablers."

Campaign Plan for the Development of Afghan National Security Forces, September 20, 2008 The plan's concept is to develop "…functioning ministries with the institutional capability to operate independently in both their internal functions and their ability to interface with the international community." This capability will develop institutional and organization expertise in logistics, acquisition, procurement, and related functions to sustain a viable ANSF.

[5] The exact percentage of line items purchased or dollars executed through each method is not available due to difficulties encountered in obtaining audit-worthy financial obligation and contract data from all three sources. See Observation 13.

[6] LOGCOM is responsible for all MoD logistics efforts, and was recently assigned responsibility for Class VIII materiel.

Discussion

Through interviews with key NTM-A/CSTC-A staff and direct observation at Forward Supply Depots (FSD), the National Military Hospital (NMH) and Regional Military Hospitals (RMH), we found that a significant portion of medical supplies and equipment used at ANA facilities and in ANA warehouses were from U.S. sources, were funded with U.S. dollars, or were obtained through U.S. procurement methods. Continued multi-million dollar shipments of vaccines, pharmaceuticals, supplies and equipment from U.S. acquisitions are necessary for financial reasons but do not further the goal of creating an autonomous ANA Class VIII supply chain capable of standing on its own. If anything, this supply mechanism perpetuates a dependency condition wherein the ANA relies to a large measure on the U.S. to sustain the ANA HCS.

By way of contrast, we visited Wazir Akbar Khan Hospital (WAKH), a Ministry of Public Health (MoPH) funded public hospital in Kabul, Afghanistan. We interviewed the Hospital Director and Chief Financial Officer to learn how this facility is funded and how Class VIII is provided to the hospital. The 210-bed WAKH is funded, primarily, through United States Agency for International Development (USAID) funds given to MoPH. In turn, MoPH provides funding to two Non-Governmental Organizations (NGOs)--Tech Serv and International Medical Corps. These two NGOs facilitate the pharmaceutical and medical supply acquisition process using World Health Organization-approved sources while following Government of Afghanistan Procurement Law.

The model used to fund WAKH and acquire Class VIII is worthy of further examination by the CSTC-A staff. It is clear the ANA does not have sufficient funding and will not have sufficient funding for its HCS for years to come. Nonetheless, an interim step toward building ANA ownership and decreasing reliance on predominantly U.S. acquisition channels could be providing funds to MoD, which in turn partners with a third party to facilitate medical acquisition.

If the ANA does not gain greater control over Class VIII acquisition, it will not be positioned to provide basic medical logistics support for its HCS. The CSTC-A Campaign Plan is focused on ANSF autonomous operations at the ministerial level. We interpret this focus to mean that the ANA Class VIII supply chain should ultimately be an ANA-procured, ANA-funded, and ANA-controlled function. In order to achieve this end state, NTM-A/CSTC-A must partner with key Afghan ministerial-level personnel to build a roadmap and capacity building plan so the ANA can begin to operate functions pursuant to ultimately managing its own independent Class VIII supply chain.

Recommendations

1. NTM-A/CSTC-A partner with LOGCOM and OTSG to develop and implement a plan to transition, where feasible, Class VIII requirements generation and acquisition processes to the MoD.

Management Comments

NTM-A/CSTC-A concurred with Recommendation 1 with the following response.

NTM-A/CSTC-A is taking action to transition requirements generation and acquisition of Class VIII material/supplies to the MoD. During this transition period, NTM-A/CSTC-A will work to put in place a capability to procure Class VIII material through local acquisition processes or through Foreign Military Sales.

Our Response

NTM-A/CSTC-A comments to Recommendation 1 were responsive. No further comments are required.

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Observation 2: Incorporation of Class VIII supply management under MoD/LOGCOM has not been fully implemented

Although the Minister of Defense has issued guidance specifying Class VIII supplies now fall under the purview of MoD Logistics Command (LOGCOM), this policy has not been applied across the ANA medical logistics system.

This appeared to result from a lack of endorsement for the policy by the MoD Surgeon General, refusal to apply it among Forward Supply Depot (FSD) commanders, and lack of MoD oversight.

As a result, the MoD effort to provide for an integrated MoD logistics system, to include Class VIII materiel, has not been fully implemented as intended.

Applicable Criteria

MoD Decree 4.0 "Supported and Supporting Unit Logistics Policy and Support Procedures," January 2009 This document is the basic MoD policy guidance for ANA logistics doctrine and guidance. The only specific references to Class VIII responsibilities are assisting the Office of the Surgeon General (OTSG) in developing medical logistics or inclusion of medical issues in unit responsibilities.

MoD Decree 4.2 "Materiel Accountability Policy and Procedures," June 2009 The document establishes the policies and procedures for the MoD for materiel accounting. It includes guidance on specific policies e.g. general accounting for expendable equipment and supplies, and specific procedures e.g. filling out the Property Book.

MoD Order #4448 to establish a new mechanism for logistics accountability, August 9, 2010 The document directs that the supply depots of the OTSG be transferred to the Forward Depots of the Logistics Command of AT&L.

Discussion

The Minister of Defense issued an order in August 2010 with the objective of solidifying the intent of Decree 4.0 such that all classes of supply (including Class VIII) would fall under the management and oversight of LOGCOM. The original intent of Decree 4.0 was for Class VIII to be included. However, the MoD Office of the Surgeon General (OTSG) has resisted this consolidation. As a result, Class VIII has been under OTSG responsibility since 2006. Prior to the MoD order, all medical FSD Commanders reported through OTSG channels and operated autonomously from the overall LOGCOM FSD Commander (a line i.e. non-medical, ANA Officer).

MTAG mentors have provided some Medical FSD Commanders a copy of the MoD letter; at least one FSD Commander (ANA Colonel) has also received a copy. However, these commanders are unwilling to implement the change until LOGCOM AND OTSG provide implementing guidance and communicate this change. According to an NTM-A/CSTC-A

official, OTSG is aware of MoD's letter; however, there is little indication of active OTSG support of the policy.

The lack of OTSG and LOGCOM coordination and implementing instructions and oversight for the MoD's decision has resulted in no actual administrative change for Class VIII support throughout the ANA. The conditions detailed in this report related to non-adherence of MoD Decrees 4.0 and 4.2, as they apply to Class VIII materiel, will continue until active OTSG support of the policy occurs and implementing instructions are disseminated. OTSG continues to execute control over Class VIII materiel at all levels with only superficial deference to LOGCOM oversight and control.

The NTM-A/CSTC-A CJ4 and Surgeon should simultaneously work with their ANA counterparts in advising them to build implementing guidance and provide oversight to ensure compliance. This guidance should make clear where OTSG lines of responsibility begin and end for Class VIII funding, requirements generation, acquisition, and management, and re-emphasize at what levels of ANA these responsibilities exist. Similarly, LOGCOM's lines of responsibility must be clearly defined. Finally, once implementing guidance is available, it must be officially communicated directly from the appropriate chain of command to Corps Commanders, the NMH Commander, RMH Commanders, Medical FSD Commander and overall FSD Commanders so no mis-understanding occurs as to the nature and requirements of the guidance. Follow-up oversight by MoD and U.S. military mentors will be necessary given ANA's track record of non-compliance with MoD logistics guidance.

Recommendations

2a. NTM-A/CSTC-A advise and assist LOGCOM and OTSG to define where LOGCOM and OTSG Class VIII responsibilities begin and end.

2b. NTM-A/CSTC-A advise and assist LOGCOM and OTSG to develop a formal implementation plan for LOGCOM assumption of Class VIII responsibility.

2c. NTM-A/CSTC-A advise and assist LOGCOM and OTSG to formally communicate changes in Class VIII support to all levels of the supply chain.

2d. NTM-A/CSTC-A advise and assist LOGCOM and OTSG to provide follow-up oversight to ensure compliance

Management Comments

NTM-A/CSTC-A concurred with Recommendations 2a, 2b, 2c, and 2d with the following response.

Recommendation 2a. The Minister of Defense signed order #4448 transferring the supply depots from OTSG to Logistics Command of AT&L in Solar Year 1389 (2010). OTSG, now Medical Command (MEDCOM), has been and continues to be advised on where their responsibility ends and Logistics Command (LOGCOM) responsibilities begin. The MEDCOM Commander publicly acknowledged the move, precipitated by a GS mentor mediated call from the Vice Chief of the General Staff to reinforce the fact that Class VIII does not belong to MEDCOM. On 25

April 2011, NTM-A/CSTC·A facilitated a meeting between the Chief, LOGCOM, and the Deputy MEDCOM Commander for Administration and Operations. This first ever meeting clearly laid out the responsibilities of the two organizations with full concurrence.

Recommendation 2b. The implementation and assumption of Class VIII by LOGCOM is complete. The medical depots in the regions know they now work for the FSD commander and NMH is getting its support directly from the Class VIII warehouse per Decree 4.0. We continue to train and mentor the process at every level.

Recommendation 2c. The change has been officially communicated on numerous occasions. See response 2a. NTM-A/CSTC-A will continue to monitor the situation to determine if a formal memorandum from the MEDCOM commander is necessary.

Recommendation 2d. Class VIII has been added to the Logistics Validation Team site surveys. The Logistics Training Advisory Group (LTAG) and Medical Training Advisory Groups (MTAG) conduct continuous Battle Field Circulations and provide daily follow-up as part of their mentoring duties.

Our Response

NTM-A/CSTC-A comments to the Recommendations were responsive. No further comments are required.

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Observation 3: Class VIII FMS acquisition was not properly planned and coordinated with MoD/ANA stakeholders

NTM-A/CSTC-A medical mentors have only limited coordination with ANA medical units during the requirements generation process leading to Class VIII FMS acquisitions.

This was due to NTM-A/CSTC-A not having a formal coordination process for FMS acquisitions to capture customer requirements, validate them, and communicate final plans to ANA customers.

Not soliciting customer input regarding requirements limits HCS practice and ability to forecast patient care capacity and creates the effect of critical shortages at all levels of the supply chain. Conversely, excess and unneeded stocks are ordered because items supplied were often not needed and stocked in too great a quantity. Finally, if the customer's true needs are not accurately identified then an atmosphere of mistrust in the supply chain is perpetuated at every level.

Applicable Criteria

DoD 5105.38-M "Security Assistance Management Manual," October 3, 2003 This document provides policy and procedural guidance on processing security assistance requests, including FMS. Chapter 5 discusses the FMS case development process and notes "Purchaser involvement early on in the [Letter of Acceptance] development process is essential to ensure the final document provides the best "fit" for their requirements. Purchasers should be encouraged to attend meetings and receive correspondence designed to clarify [Letter of Request] information...there are many instances where purchaser participation and input are necessary."

DoD 4140.1-R "DoD Supply Chain Materiel Management Regulation," May 23, 2003 This document provides guidance on materiel management including "developing materiel requirements based on customer expectations while minimizing…investment in inventories [and] selecting support providers on the basis of best value…"

Army Regulation 12-1 "Security Assistance, Training, and Export Policy," July 23, 2010 This document provides guidance to Army entities involved in security assistance provision. One section discusses "development of an offer requires a coordinated and tailored approach based on an in-depth assessment of the maintenance, supply, and training capabilities of the recipient, the adequacy of its logistical infrastructure, support base, trainable labor base, and experience with similar equipment."

Campaign Plan for the Development of Afghan National Security Forces, September 20, 2008 This document provides an overarching strategy on the development of the MoD and MoI. The objective is to ensure security sector development efforts are synchronized among the MoD, MoI and NTM-A/CSTC-A, and the wider International Community.

Discussion

Ideally, Class VIII requirements are developed within the supply chain, beginning with medical facility bedside and operating room supply, pharmaceutical and equipment needs. The data accumulation should continue all the way through the discharge process and outpatient pharmaceutical dispensing. In addition, depot stockage levels have to be included.

Achieving awareness and buy-in from the stakeholders utilizing Class VIII is paramount. Requirements generation should begin at the lowest levels of a supply chain. However, interviews with stakeholders within the ANA Class VIII supply chain indicated that ANA higher headquarters (OTSG and NTM-A/CSTC-A) decided what and how much to purchase, and how much to distribute, with little end-user input.

MTAG mentors and ANA medical staff reported little or negligible engagement with either OTSG or NTM-A/CSTC-A staff prior to large Class VIII FMS procurements and arriving shipment. NTM-A/CSTC-A medical logistics mentors were not consistently provided advanced notice of shipments to share with MoD/ANA counterparts. Those few MoD/ANA staff who were engaged prior to the FMS Letter of Acceptance (LOA) generation were rarely provided feedback on which requirements would be filled. They were not given the opportunity to justify their requirements prior to the LOA being locked-in. Rather, MoD/ANA customers had simply to wait for shipments hoping or assuming all their requirements would be fulfilled, in the quantities requested, to accomplish their medical supply mission.

Some RMH Commanders had only a $3,000 quarterly emergency pharmaceutical budget to execute at their facilities. Hence, they were largely dependent on OTSG and NTM-A/CSTC-A funded acquisitions to support their missions. As one RMH Commander reported, higher headquarters sends stocks downward implementing “their plan” and not “our plan.”

The absence of detailed electronic patient records, diagnosis and prognosis make it difficult to quantify the numbers and types of patient encounters throughout the HCS. Critical pathways for patient care revealing typical supply and pharmaceutical consumption at the patient encounter level were not available at the RMH or Corps levels. As a result, acquisition planners were forced to rely on previous purchases as consumption history to determine future buys. The problem with this method was that customer demands were not accurately captured resulting in repeated shipments of the same product.

Finally, there is a general attitude among FSD and RMH Commanders that higher headquarters officials did not trust their experience and expertise and, as such, would not seek their input in determining their own medical logistic needs. Despite the fact MTAG mentors are on-site at all levels of the supply chain, senior decision makers do not always include them and their ANA mentees when established requirements upon which future acquisition decisions would be based. The phenomenon of “we know best” appears to be ever-present. Conversely, when the basic MoD Form 14[7] supply request forms were not filled, with no feedback provided to customers, mistrust of higher headquarters down the supply chain was amplified.

[7] MoD Form 14 is the form used to request materiel of any kind in the MoD logistics system.

Recommendations

3a. NTM-A/CSTC-A, in coordination with MoD and ANA, build a FMS requirements generation process, starting with the lowest levels of RMHs, concluding with RMH Commander and appropriate OTSG staff approval.

3b. NTM-A/CSTC-A, in coordination with MoD and ANA, create a feed-back loop to inform RMH and depot staff which requested items will be filled, which will not, and the reason(s) why.

Management Comments

NTM-A/CSTC-A concurred with Recommendations 3a and 3b with the following response.

Recommendation 3a. The next FMS case will be based on the ANA Solar Year (SY) 1390 requirements. The SY1390 requirements were built using input from RMH, Corps and below units, SOF, the ANA, Afghan Air Force, and other units. The ANA will use their 351 million Afghani SY 1390 budget to buy the requirements they can and request NTM-A/CSTC-A to purchase the remaining requirements. The SY 1390 requirements were sent to the RMH so they could re-validate and have the opportunity to provide feedback before any purchases are made. NTM-A/CSTC-A is directing mandatory logistics training for all mentors so they understand the process.

Recommendation 3b. The Logistics Support Operations Center (LSOC) in coordination with NTM- A/CSTC-A is developing an automated system to pass the status of parts on-order through the chain of command for the due-in date. Additionally, for the feed-back loop, LSOC created a MoD Form 14 Tracker that units can reference to make sure their MoD Form 14s were received and submitted to the Class VIII warehouse. LSOC also created a customer service line for customers to check on status of requisitions. The ANA and mentors work together to utilize the system to check on the status of their MoD Form 14s.

The system exists in the Decrees; the mentors encourage their mentees to use the proper forms according to their Decrees. Customers in the ANA use the MoD Form 14 process to request items as per the ANA Decrees. If less than the full amount on the MoD Form 14 is available, then the logistics nodes (i.e. FSDs, Corps G4s, FSG, and LSOC) use a MoD Form 2 (Stock Accounting Record) to record the issues and receipts. This is a basis to audit for materiel accountability, distribution for arriving materiel due-in, and a means to periodically validate due-in demands with each supporting depot. In conjunction with the MoD Form 2, logistics nodes use a MoD Form 1298 (Due-Out Log) to establish a record of the materiel/stocks owed to a supported unit until all requests are completed/completely filled with stock as requested. The logistics nodes retain the MoD Form 1298 with the MoD Form 2 that it is associated with. Items not available through the supply system, if deemed required, are acquired through NTM-A/CSTC-A FMS for Foreign Military Sales and/or through NTM-A/CSTC-A Local Acquisition for local acquisition items as well as through the ANA Procurement Agency. Attached is an example of the tracking document that shows how they verify/track the MoD 14's.

Our Response

NTM-A/CSTC-A comments to the Recommendations were responsive. No further comments are required.

Observation 4: A defined Authorized Stockage List (ASL) has not been established for the ANA Class VIII supply chain

An ASL is lacking within the ANA logistics chain, which means a baseline listing of Class VIII standard requirements for HCS operations at all levels is unavailable.

This occurred because NTM-A/CSTC-A, in coordination with MoD and ANA, had not developed medical ASLs for each respective medically-related facility in the ANA (FSDs, NMH or RMHs).

The lack of a defined ASL negatively impacts requirements generation (affecting forecasting and acquisition), and fulfillment (receipt and issuance) processes.

Applicable Criteria

MoD Decree 4.0 "Supported and Supporting Unit Logistics Policy and Support Procedures," January 2009 Section 5-1 discusses the concept and use of an ASL in the MoD logistics system. Section 4-1 speaks to use of "stock records, demand data, and selective stockage…These elements constitute the Stock Record Accounting (SRA) system…[which] provides the basis for recommending items for inclusion on the ASL (selective stockage based on demand criteria)."

DoD 4140.1-R "DoD Supply Chain Materiel Management Regulation," May 23, 2003 Section C1.3 mandates materiel management goals which include having to "maintain materiel control and visibility of the secondary inventory down to and including retail[8] inventories."

Section C.2.1 discusses demand and supply planning, which includes balancing inventory and customer demand, balancing defined as "actions needed for provisioning new materiel, for determining peacetime and wartime replenishment stockage levels, and for retaining material assets."

Section C.5.3 discusses requisitioning and stresses retail supply activities should have visibility of the wholesale inventory; submitting requisitions is the prerogative of the submitter; and priority of demand may be specified.

AP1.1.10 defines cataloging as "the act of naming, classifying, describing, and numbering each item repetitively used, purchased, stocked, or distributed to distinguish each item from very other item…[including]…the maintenance of information related to the item and the dissemination of that information to item users."

[8] "Retail" is defined as a "level of inventory below the wholesale level, either at the consumer level (directly supporting customers) or at the intermediate level (supporting a geographic area)."

Discussion

At all levels of the ANA Class VIII supply chain an attitude existed in which there was mistrust of whether a bona fide need existed for products requested. In addition, MoD Form 14s were routinely rejected because suppliers at all levels do not have clear guidance on what is and what is not authorized for issuance to a particular customer.

Our assessment revealed examples in which an FSD Commander rejected a MoD Form 14 supply request for a particular customer because he believed the end user was not qualified to possess or utilize the drug being ordered. Without established ASLs, these decisions were unpredictable. Regardless, little feedback was provided to the customer explaining the rationale and reasoning behind the MoD Form 14 rejection.

Building ASLs (or a similar product) for units at all levels, with maximum order or stock on-hand authorizations, will help streamline the order fulfillment process, and avoid arbitrary denial of supply requests. Furthermore, these ASLs will provide the basis for a non-pharmaceutical formulary/ASL to be utilized by senior acquisition planners. The ASLs will help planners build forecast templates based on bona fide and authorized need, restoring some level of credibility to the whole Class VIII supply chain.

Recommendations

4a. NTM-A/CSTC-A, in coordination with OTSG, develop ASLs for each RMH department and pharmacy.

4b. NTM-A/CSTC-A, in coordination with LOGCOM, develop ASLs and requisition objectives for medical FSDs.

4c. NTM-A/CSTC-A establish an alert system to indicate, based on feedback from medical mentors down the supply chain, when MoD Form 14 orders are not filled, and provide this feedback to MoD for reconciliation purposes.

Management Comments

NTM-A/CSTC-A concurred with Recommendations 4a, 4b, and 4c with the following response.

Recommendation 4a. The RMHs are in the process of collecting usage data so they can begin to establish their local inventory levels at the RMH. Each RMH has a contractor who is tasked to collect that information and have it available by June 2011.

Recommendation 4b. All RMHs and the NMH submitted their SY 1390 requirements. LOGCOM uses the SY1390 requirements as the starting point for creating the Class VIII ASL. Upon establishment of the ASLs, Logistics Support Operations Center, and the FSD/Class VIII warehouses set appropriate requisition objectives in order to help maintain the correct amount of stock on hand at all times at the FSDs and CLVIII warehouses. Mentors help their mentees to select the appropriate requisition objectives based on historical data. The FSDs and Class VIII warehouses use the MoD Form 14 to reorder CLVIII supplies once stock reaches the requisition objective point.

Recommendation 4c. Please reference response 3b.

Our Response

NTM-A/CSTC-A comments to the Recommendations were responsive. No further comments are required.

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Observation 5: The Afghan National Army did not have a standardized list of medications and consumable supplies

The medical logistics system does not have an established drug formulary[9], and corresponding ASL, for medications and related consumables to be stocked at each level of the supply chain in meeting medical system supply needs. The lack of a medication formulary, along with consistent collection and reporting of usage data, contribute to a medical logistics system that lacks standardization and reliability.

As a result, medical treatment facility requests for medications and consumables were not consistently provided in a timely manner or provided at all. The unreliability of the logistics system has adversely impacted patient care and led to a widespread lack of confidence in the logistics capability of the ANA medical care system.

Applicable Criteria

DoD 4140.1-R "DoD Supply Chain Materiel Management Regulation," May 23, 2003 Section C.2.1 discusses demand and supply planning, which includes balancing inventory and customer demand, balancing defined as "actions needed for provisioning new materiel, for determining peacetime and wartime replenishment stockage levels, and for retaining material assets." Section C3.1 speaks to sourcing and materiel acquisition including "practices that promote the quality and cost-effectiveness throughout the supply chain."

U.S. Army Regulation 40-3 "Medical, Dental, and Veterinary Care," February 22, 2008 The regulation provides guidance on policies and procedures for selected Medical Department programs and initiatives. Chapter 11 deals with Pharmacy and Medication Management, Section 11-2 (a) (1) (c) stipulating "Drug dispensing is based on a formulary system,"

WHO Model List of Essential Medicines 16th list (updated), March 2010 The document provides a core list of "minimum medicine needs for a basic health-care system, listing the most efficacious, safe and cost-effective medicines for priority conditions." A complementary list of essential medicines is also provided for priority diseases requiring specialized diagnosis, monitoring, or care.

Discussion

We found at medical treatment facilities visited that they did not have a catalog of medications and related consumables available from their supporting FSD; we also noted a similar lack of a product catalog at the National Military Class VIII depot. Orders for medications were based upon previous submissions and annual requirements. The process to approve and provide a new medication or related consumable for future order was not defined.

[9] The American Society of Hospital Pharmacists defines a drug formulary as "A continually updated list of medications and related information, representing the clinical judgment of physicians, pharmacists, and other experts in the diagnosis and treatment of disease and promotion of health." A related system is "An ongoing process whereby a health care organization…establishes policies on the use of drug products and therapies, and identifies [those] that are the most medically appropriate and cost-effective to best serve the health interests of a given patient population."

The ANA medical treatment facilities visited reported that routine resupply orders were accepted monthly. Urgently needed items could be ordered and filled, if available at the regional depot. All regional medical depots reported that it was common not to receive supplies ordered via a MoD Form 14 for extended periods of time and when supplies were received, quantities requested were routinely cut.

The common theme articulated was that the medical logistics system was unreliable, unresponsive, and out of touch with the needs of supported depots and military treatment facilities. A beginning step in improving support and responsiveness should be the publication of a catalog of medications and supplies readily available for supply to customers, along with an instruction that provides guidance on the acquisition of equipment and items not contained within the catalog.

Recommendations

5a. NTM-A/CSTC-A, in coordination with the Office of the Surgeon General (OTSG), establish a standardized list of needed pharmaceuticals (drug formulary) and related medical supplies. The list of medications should be based upon the current National Licensed Drug list promulgated by the Ministry of Public Health.

5b. NTM-A/CSTC-A, in coordination with the OTSG, establish authorized stock lists specific to medications that are based on the level of care provided and health care provider input.

5c. NTM-A/CSTC-A, in coordination with the OTSG, to incorporate a medication requirements generation process to obtain suggestions for medication additions and deletions to the standard list of medications.

5d. NTM-A/CSTC-A, in coordination with the OTSG, develop and disseminate product catalogs through the ANA supply chain.

Management Comments

NTM-A/CSTC-A concurred with Recommendations 5a, 5b, 5c, and 5d with the following responses.

Recommendation 5a. A formulary was established for SY1389. OTSO has established a standardized SY1390 medication formulary and respective quantity requirements per the attached document. This list is based upon the National list promulgated by MoPH.

Recommendation 5b. ANA is underway with implementing an electronic inventory management system, CORE IMS. This is a precursor step supporting the establishment of inventory levels for individual work centers and hospital departments. Pharmacy mentors established ASLs for pharmaceuticals. Also see response to 4a.

Recommendation 5c. MEDCOM currently coordinates an annual and ad hoc Pharmacy Therapeutics Committee for generating annual ANA medication formulary updates and

respective quantity requirements. This committee has existed since 2006. Original policy attached.

Recommendation 5d. The Core Inventory Management System (CORE IMS), which is currently being fielded, has catalog information. 1st FSD, 2nd FSD, 3rd FSD and 4th FSD have the ability to utilize CORE IMS. Every time a new item is entered into CORE IMS a unique number is created to identify that item through the material control register. Customers can log into CORE IMS and print the catalog information. If for some reason the RMH or TMC's can't access CORE IMS they can get hard copy catalog information from the FSD or National Supply Depot (NSD).

Our Response

NTM-A/CSTC-A comments to the Recommendations were responsive. No further comments are required.

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Observation 6: ANSF leaders reported a lack of confidence in the quality of pharmaceuticals supplied from MoD purchased sources

The general lack of confidence in the quality of medications supplied was a concern raised by key MoD leaders interviewed.

This perception was due to an ANSF acquisition system which allows for a single decision maker to disregard recommendations of subject matter experts and choose to select the lowest cost bid. This can compromise quality, promote user belief that quality medications are exchanged with lesser quality products for personal profit; and lead to issuance of counterfeit or expired medications.

The lack of quality pharmaceuticals has both direct and indirect effects including:

- by introducing counterfeit morphine into the supply system, the availability of potent morphine cannot be guaranteed
- by introducing expired medications into the supply system, the availability of current unexpired medications cannot be guaranteed.
- a lack of confidence throughout the ANSF in the availability of quality pharmaceuticals in the treatment of patients

Applicable Criteria

Campaign Plan for the Development of Afghan Military and Police Forces, September 2008 The plan states that Medical Command is responsible for providing quality health care to ANA personnel, designated family members and other beneficiaries and for preparing medical facilities and combat medical units to deliver quality care during times of peace and war.

WHO Policy Perspectives on Medicines 7 "Effective medicines regulations: ensuring safety, efficacy and quality," December 2003 The document discusses the nature and need for medicine regulation noting "The use of ineffective, poor quality, harmful medicines can result in therapeutic failure, exacerbation of disease, resistance to medicines…[and] undermines confidence in health systems [and] professionals…Money spent on ineffective, poor quality medicines is wasted…."

WHO Model List of Essential Medicines 16th list (updated), March 2010 The document provides a core list of "minimum medicine needs for a basic health-care system, listing the most efficacious, safe and cost-effective medicines for priority conditions." A complementary list of essential medicines is also provided for priority diseases requiring specialized diagnosis, monitoring, or care.

Discussion

In MoD staff interviews we conducted, concern was expressed regarding pharmaceutical product quality and also lack of availability of key medications. Lack of confidence in the medical supply chain was also clearly articulated. The decision to transition from an OTSG-managed logistics system to a LOGCOM managed logistics system exemplified the level of frustration with OTSG's practices.

Acquisition

The current MoD Acquisition, Technology and Logistics (AT&L) Acquisition Agency procedure for purchasing pharmaceuticals allows for the consideration of quality in the procurement process. An Evaluation and Selection Committee, which includes pharmacy representation from the OTSG, is charged with assessing bids on solicitations to ensure the contracted products will meet quality requirements. During our assessment it became clear that the final decision maker for selecting contractors exclusively selected the lowest bidders. This was a point of considerable frustration among MoD/ANA participants involved in contributing to the selection process.

For comparison purposes, we performed an analysis of 4 bids submitted by vendors for a set of required vaccines and compared them to FMS pricing[10]. Vendor source or quality standards for the vaccines were not specified in any bid. Our analysis showed:

- Vendor bids were all lower than FMS prices except for 1 vendor quote for 1 vaccine
- Quotes ranged from 2% to 79% of FMS pricing
- One vendor was consistently and unusually low in unit pricing in comparison to the other vendors (raising the concern of how such prices were possible if obtained through legitimate manufacturers)

Given this comparison, AT&L purchasing practices would result in the low cost bidders receiving the awards. Since the vendors discussed in the above analysis did NOT specify the source for the vaccines or otherwise indicate the drug met Food & Drug Administration (FDA), World Health Organization (WHO) or United Nations Children's Fund (UNICEF) quality standards, there was a consequent risk that sub-standard vaccines might have entered the ANA HCS and affect troop health.

The MoPH was able to purchase quality pharmaceutical products at lower cost using WHO/UNICEF validated sources through the assistance of USAID. Likewise the NTM-A/CSTC-A mentor team supporting the MoI medical mission was in the process of providing alternate vendors of vaccines that would provide WHO/UNICEF validated sources at a more competitive price than the United States Army Medical Material Center, Europe (USAMMCE), the source of U.S. FMS Class VIII materiel supplied to the ANA. However, the Defense Security Cooperation Agency (DSCA) directed CSTC-A to only procure vaccines and pharmaceuticals from US Food and Drug Administration approved sources. The Command Surgeon developed a waiver request to the DSCA but due to perceived risks for pursuing the strategy within the command, the waiver package was not forwarded to DSCA.

[10] FMS purchases are required to obtain only FDA-approved drugs or sources.

The Command Surgeon can obtain quality vaccines and pharmaceuticals through regional distributors at an approximate savings of 40% if granted the waiver. The long term transition strategy to facilitate the Afghans purchasing their own vaccines and pharmaceuticals would be enhanced by CSTC-A building the relationship and supply chain with regional vendors now using Afghan Security Force Funds. Once systematic processes are in place, CSTC-A could then assist the Afghan National Security Forces (ANSF) to develop a Prime Vendor relationship with the same regional distributors that meet quality and efficacy standards.

The ability to limit vendor selection to WHO/UNICEF approved vendors will require a mandate from the Minister of Defense. Such an edict would change the current paradigm of lowest cost to one of lowest cost from a vendor that must provide pharmaceuticals from WHO/UNICEF validated sources. This change would restore confidence in the quality of medical supplies and pharmaceuticals provided through the class VIII logistics chain.

An alternative option to ensure quality would be to continue purchasing annual requirements, as is the current practice, and conduct potency testing to determine quality. This option would require the establishment of testing facilities, development of intellectual infrastructure (the MoD currently does not have this capacity), and lead to increased complexity and oversight of class VIII management. Use of WHO/UNICEF validated vendors provides a more immediate solution to resolve quality concerns of pharmaceuticals.

Medication Quality

During site visits to RMHs and FSDs, we observed in one location counterfeit morphine packages were still in stock. The drug was physically isolated from regular stock in a cabinet and area that can be physically secured. However, there was no signage or other means to warn staff not to place the drug back into regular stock, thus ensuring it is not used to fill supply requests. Similarly, we noted elsewhere expired medications physically separated but still available for inclusion in the supply system. Medication quality and patient care thus are impacted if these counterfeit products are issued to requestors and/or there is no quality assurance program to appropriately manage expired medications.

Recommendations

6a. NTM-A/CSTC-A advise and assist the Ministry of Defense in the issuance of a mandate that limits the selection of sources for pharmaceuticals and medical supplies to WHO, UNICEF, and FDA approved sources for central purchases through procurements to assure quality.

6b. NTM-A/CSTC-A advise and assist the Assistant Minister of Acquisition, Technology and Logistics in development and promulgation of policy that ensure contracting procedures dictate “quality trumps cost” and not “contract goes to the lowest bidder” when purchasing requirements of medications and medical supplies.

6c. NTM-A/CSTC-A revisit the feasibility of purchasing vaccines through WHO/UNICEF approved sources as a more cost-effective alternative without compromising product quality.

6d. NTM-A/CSTC-A, in coordination with the OTSG, provide timely instructions to report and remove counterfeit and expired medications from the logistics chain.

Management Comments

NTM-A/CSTC-A concurred with Recommendations 6a, 6b, 6c, and 6d with the following responses.

Recommendation 6a. NTM-A/CSTC-A continues to advise and assist the Ministry of Defense on this issue, and this was a topic of discussion during our recent Program Management Review. The desired outcome of this mandate would be to limit the selection of sources for pharmaceuticals and medical supplies to vendors that are USAID approved sources. USAID, through these vendors already provide pharmaceuticals to the Ministry of Public Health in Afghanistan.

Recommendation 6b. CSTC-A met with the Assistant Minister of Acquisition Technology and Logistics to discuss how our Acquisition Teams could work more closely together to further develop the ANA Acquisition and Procurement Strategy. The Assistant Minister designated BG Wakil (Head of the ANA Acquisition Agency) as our point of contact for CSTC-A to work on the further development of procurement strategy and policy. We continue to advise BG Wakil on both procurement policy and purchasing requirements for medications and medical supplies. Our point of view is that GIRoA Procurement Law 2008, Articles 18, 19 and 23 all address this issue and allow exceptions to the low bid contract direction for procurement.

Recommendation 6c. NTM-A/CSTC-A concurs with this recommendation and is taking action to determine the feasibility of US pseudo-FMS to purchase vaccines through non-FDA approved sources to possibly include USAID, WHO and UNICEF approved sources.

Recommendation 6d. There is language in the update to Decree 4.0 that gives units instructions on how to turn in and destroy expired items. If there are items identified as counterfeit the Class VIII NSD and FSD will inform their customers and will issue instructions on what to do IAW with Decrees. We continue to train and mentor the process at every level.

Our Response

NTM-A/CSTC-A comments were responsive. We request a six-month update on progress towards implementation of Recommendations 6a and 6c.

Observation 7: The Military Entrance Processing Station (MEPS) lacked vaccines for ANA recruits

MEPS lacked adequate types and numbers of vaccines[11] for inoculation of ANA recruits.

This shortage was due to insufficient supplies available at local depots even though the National Medical Depot had sufficient stocks on hand.

The effect of vaccine shortages is to put ANA recruits at risk for infectious disease and increased risk for spread of communicable disease due to the close quarters in which recruits reside.

Applicable Criteria

Campaign Plan for the Development of Afghan Military and Police Forces dated September 2008 The plan states that Medical Command is responsible for providing quality health care to ANA personnel, designated family members and other beneficiaries and for preparing medical facilities and combat medical units to deliver quality care during times of peace and war.

DOD Instruction 6025.19 "Individual Medical Readiness," January 3 2006 The instruction provides "defined, measurable medical elements" of medical readiness. Section E-3.2 specifies immunization status as one of those elements and notes "Immunizations effectively prevent infectious diseases in the deployed as well as non-deployed environments." The section also requires immunizations should be monitored and kept current, and specifies six standard vaccines for use.

Discussion

Immunization of the fighting force is a force multiplier which reduces the incidence and spread of communicable disease. It should be a powerful tool in maintaining the health of the fighting force by lessening the impact of disease. The ANSF has adopted, in general, the practice of immunization of recruits for these reasons. The current challenge facing both the ANA and the ANP in the near term was the availability of vaccines and supplies.

During our visit to the Kabul MEPS we discovered that only two of the six mandated vaccinations were available. According to the medical staff at the clinic, the full complement of vaccines had not been available for the last three months prior to our site visit. We also discovered that the RMH Supply Depot and clinic supporting the Herat regional training center did not have a complete complement of required vaccines.

The shortage of vaccines at the Kabul MEPS exemplified the shortcomings of the ANA medical logistics system. Needed vaccines and ancillary supplies for the Kabul MEPS were available at the Kabul Regional Depot and the National Medical Depot but had not been distributed.

[11] According to the Centers for Disease Control & Prevention, vaccines "prevent disease in the people who receive them and protect those who come into contact with unvaccinated individuals. Vaccines help prevent infectious diseases and save lives."

The lack of vaccines at the time of initial training posed immediate and long term health threats to the ANA. Recruits live in close quarters, which provide the necessary conditions to spread communicable disease. The availability of vaccines at all training sites allow for early initiation and completion of required inoculation schedules, a central point of vaccine administration and benefit for the larger community.

The U. S. Army Medical Material Center, Europe (USAMMCE) has been the supply source for ANSF vaccine requirements. Vaccines through USAMMCE come at a premium cost. Acquisition of vaccines for the ANSF in the future should consider alternate sources that meet WHO/UNICEF quality standards at reduced cost. The NTM-A/CSTC-A medical mentor team has sought to identify alternate sources and develop the ANA acquisition capability to support vaccine requirements.

A related issue is the need to have available all necessary ancillary supplies (tuberculin needles, alcohol swabs) to correctly administer the vaccines. Sufficient consumable supplies should be included in all vaccine orders based on total doses ordered for administration.

Recommendations

7. NTM-A/CSTC-A mentor the OTSG to identify vaccine requirements (projected needs) and ancillary requirements (tuberculin syringes, alcohol pads) and ensure required supplies are on hand or shipped in advance of need.

Management Comments

NTM-A/CSTC-A concurred with Recommendation 7 with the following response.

The MTAG preventive medicine section is in the process of mapping the ANA vaccine process and identifying the points of failure. CLVIII is working on establishing a vaccine Authorized Stockage Listing (ASL) based on the SY 1390 requirements. The ASL is used to help maintain the proper CLVIII items on hand at the lowest levels (NMH/ RMH/ regional CL VIII warehouses).

There is an approved SY 1390 vaccine distribution plan that covers all ANA sites. MEDCOM Chief of Preventive Medicine (PM) receives monthly updates from all the Corps and training sites. MTAG PM is going out to the sites verifying that they have the vaccine that they say they have and then tracing where the breakdown is occurring. There is some confusion with the MoD 14 process in the Regions. Some of them are getting what they order while others are not.

Preventive Medicine and Logistics mentors help their mentees to select the appropriate requisition objectives based on historical data and work together to educate the field on Decrees 4.0 and 4.2.

Our Response

NTM-A/CSTC-A comments were responsive. We request an update on the process of mapping the ANA vaccine process and identifying the points of failure when complete. We also request an update on establishing a vaccine Authorized Stockage Listing (ASL) based on the SY 1390 requirements when the ASL is finalized.

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Observation 8: ANA medical equipment was not being maintained

There currently exists no medical equipment maintenance program within the ANA HCS. Many pieces of equipment have not been inspected or calibrated since they were originally purchased several years ago.

Equipment has not been maintained because the ANA does not possess sufficient Biomedical Equipment Technicians (BMETs) to fulfill this equipment maintenance mission. NTM-A/CSTC-A had a medical equipment maintenance contract for 2009-2010, but it was largely ineffective. A final contributing factor was the lack of a deliberate medical maintenance and medical equipment visibility system. The current property book was solely paper-based.

The effect of not performing routine maintenance was inoperable equipment at all levels, causing mission degradation within the HCS.

Applicable Criteria

MoD Decree 4.0 "Supported and Supporting Unit Logistics Policy and Support Procedures," January 2009 Section 2-1 discusses maintenance as a logistics function; section 1-8.a indicates the Logistics & Readiness Directorate is responsible for maintenance activity; section 1-8.h details the responsibilities of the Central Workshop for equipment maintenance.

DoD 6010.13-M "Medical Expense and Performance Reporting System for Fixed Military Medical and Dental Treatment Facilities Manual," April 7, 2008 The manual defines biomedical equipment repairs as a function which "provides preventive maintenance, inspection, and repair of medical and dental equipment. It conducts a systematic inspection of equipment to determine operational status, and assigns serviceability condition codes to equipment; and performs scheduled preventive maintenance of medical and dental equipment…[and] repairs or replaces worn or broken parts; rebuilds and fabricates equipment or components; modifies equipment and installs new equipment…"

Discussion

All medical equipment items require some level of annual maintenance in accordance with manufacturer specifications. Many items require routine software updates to ensure continued operability. Life support equipment items used in anesthesia and intensive care units typically require routine maintenance every 6 months. In some cases, RMHs do not possess backup units to rapidly replace inoperable equipment. If the one radiology unit at a RMH goes down then the diagnostic abilities of the RMH will be significantly hampered.

The RMHs and NMH have broken equipment items in sufficient numbers to negatively impact the HCS mission. For example, some RMHs reported repairs to radiology equipment taking over a month to occur. A NTM-A/CSTC-A contract was in place in the previous year to solve this problem, but was largely ineffective and is no longer in place. A new contract for medical maintenance was funded by NTM-A/CSTC-A, but has not yet been awarded by KRCC. The new contract will provide 24-hour medical maintenance support and two BMETs on-site at the

NMH and all RMHs. An interim maintenance solution (until the main contract takes effect) is under development to address immediate issues throughout the regions.

There is little organic ANA or NTM-A/CSTC-A capacity to repair medical equipment. NMH has BMETs on the Tashkil[12] and some of these positions are filled. However, the NMH BMETs' capacity to actually maintain medical equipment is unknown. The volume of broken equipment at the NMH and anecdotes from staff and MTAG mentors suggest medical equipment maintenance problems at the NMH.

For RMHs, there is no medical equipment maintenance capacity and BMETs are not on the RMH Tashkil. Rather, the ANA/G4 Tashkil has placed BMETs on the FSD-level Tashkil, but these positions are largely unfilled. The FSD-level BMETs are designed to work at the direction of the Medical FSD Commander and serve a regional role. We recommend dedicated BMETs be placed on the RMH Tashkil to ensure adequate BMET support to RMHs. The ANA BMET training program is expected to begin in 2011.

Recommendations

8a. NTM-A / CSTC-A partner with appropriate ANA directorates to fill FSD Biomedical Equipment Maintenance vacancies.

8b. NTM-A / CSTC-A mentor the OTSG/G1 to adjust the Tashkil in order to place Biomedical Equipment Technicians at all RMHs.

8c. NTM-A / CSTC-A mentor the OTSG to develop a deliberate medical maintenance and medical equipment visibility system to supplement the current property book.

Management Comments

NTM-A/CSTC-A concurred with Recommendations 8a, 8b, and 8c with the following response.

Recommendation 8a. The real problem is the lack of an available pool of trained BMET workers to fill these positions. The most sustainable course of action is the BMET training course, with a bridging contract to cover the gap between the start of the program April 2011 and when these students will be able to perform their craft independently. A pending Medical Maintenance contract(s) will take care of all ANA MEDCOM facilities and will have 2 additional option years. At present we have interim repairs/maintenance ready to execute at: Darulaman, Gardez, Herat, Jalalabad and Kabul.

IJC and NTM-A/CSTC-A are working to define equipment maintenance needs for Corps and below medical assets. This estimate should be complete by July 2011.

Recommendation 8b. The 1390 Tashkil MEDCOM numbers are good overall but need to be realigned for some locations/positions. Current MEDCOM BMET manning has remained

[12] The Tashkil describes the authorized strength and structure of an ANSF organization.

unchanged since 1389. Regional BMET positions need to be returned to the RMCs. NTM-A/CSTC-A is working this issue for the 1391 Tashkil.

Recommendation 8c. The Medical Equipment Management Office policy is in the draft stages. This will augment the base property book and provide a more comprehensive plan to account for medical equipment located within the facility. NMH currently has a MEMATS (Medical Equipment Management and Tracking System) program. This program is in the final stages of development by RANA technologies to track all medical assets within the facility. This will provide details of life cycle management in addition to a scheduled and unscheduled maintenance program. The sustainability of this program is being assessed and an alternate off-the-shelf maintenance/accountability program is being considered at this time.

Our Response

NTM-A/CSTC-A comments were responsive. We request updates when the pending medical maintenance contract(s) are in place and on the work to define equipment needs for Corps and below medical assets estimated to be complete by July 2011. We also request an update on efforts to return regional BMET positions to the RMCs through the SY 1391 Tashkil. We request a copy of the Medical Equipment Management Office policy when final and an update on the assessment of the sustainability of the RANA Technologies tracking program versus consideration for an off-the-shelf program.

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Observation 9: Requisitions submitted to FSDs and the National Depot were not acknowledged

MoD Form 14s submitted to the National Depot were infrequently acknowledged. MoD Form 14s submitted to FSDs were typically acknowledged only if personally delivered to the FSD by the customer. As a result, only RMHs co-located with FSDs typically receive order acknowledgment. When orders go unfilled, customers have no means for discerning the cause and simply reorder in an attempt to satisfy their requirement.

Based on discussion and observation we believe the apathy of, and lack of accountability by, depot staffs and the lack of relevant stock at the FSDs and National Depot may be contributing factors.

The net effect of orders not being acknowledged was customers routinely ordered the same product repeatedly. A secondary effect was the possibility of multiple shipments eventually being sent for orders, exacerbating potential excess problems. In the end, not providing standard customer service responses to requester's orders created significant uncertainty and lack of credibility in the supply system when medications and other medical supplies were not received.

Applicable Criteria

MoD Decree 4.0 "Supported and Supporting Unit Logistics Policy and Support Procedures," January 2009 Section 2-1 identifies Supply as a logistics function for "Acquiring, managing, receiving, storing, and issuing all classes of supply…." Section 7-1.a describes the MoD Form 14 as the basis for materiel requests.

DoD 4140.1-R "DoD Supply Chain Materiel Management Regulation," May 23, 2003 Section C1.3 mandates materiel management goals which include having to "maintain materiel control and visibility of the secondary inventory down to and including retail inventories." Section C.5.3 discusses requisitioning and stresses retail supply activities should have visibility of the wholesale inventory; submitting requisitions is the prerogative of the submitter; and priority of demand may be specified.

Discussion

At the four FSDs co-located with RMHs, ANA staff or NTM-A/CSTC-A mentors report multiple MoD Form 14s being submitted to the National Depot over the past several months with no acknowledgement of receipt or action taken by the National Depot. When FSDs follow-up on orders, timely responses are not forthcoming and in many cases, no response to the follow-up is received. As a result, customers have no option but to reorder the required goods that have gone unfilled or to seek alternate means for meeting their requirement.

The practice of repeating unfilled orders could be avoided by the establishment of a reliable feedback mechanism that acknowledges receipt and acceptance on an order and provides information on the orders status.

Although MoD Decree 4.0 clearly specifies procedures for handling and recording MoD Form 14 denials, NTM-A/CSTC-A and ANA staff we spoke with do not believe the procedures were followed. Customers at all levels reported poor customer service and a general apathy on behalf of the National Depot and FSDs.

Recommendations

9a. NTM-A/CSTC-A, in partnership with LOGCOM, create a feedback mechanism acknowledging MoD Form 14 receipt and acceptance.

9b. NTM-A/CSTC-A, in partnership with LOGCOM, create a process with customers to reconcile materiel requests sent to and received by the National Medical and Forward Supply depots to avoid distribution of duplicate items.

Management Comments

NTM-A/CSTC-A concurred with Recommendations 9a and 9b with the following response.

Recommendation 9a. Logistics Support Operations Center (LSOC) created a MoD Form 14 Tracker for units to reference to make sure their MoD Form 14s are received and submitted to the Class VIII warehouse. Additionally, LSOC created a customer service phone line for customers to check on status of requisitions. At each of the established FSDs, as well, there is a customer service representative to check on status of requisitions. The ANA and mentors work together to utilize the system to check on the status of their MoD Form 14s. Additionally, mentor / ANA training classes emphasize proper procedures for filling out the MoD Form 14.

Recommendation 9b. In the past, the National Supply Depot (NSD) pushed material to the FSDs causing duplicate distribution of items; now, the Class VIII NSD does not plan to push any materiel to the FSDs. Customers request items solely via the MoD Form 14 Process detailed in the ANA Decrees.

Our Response

NTM-A/CSTC-A comments were responsive. No further comments are required.

Observation 10: Unfilled Class VIII requirements were not systematically captured

Across the Class VIII supply chain, most MoD Form 14s were either "filled or killed" (supplies not issued), and no record of unfilled demands was maintained at any level. In many cases, customers first inquired as to what stocks were available at the FSD-level and then placed their orders, rather than utilizing MoD Decree 4.0 policy allowing for the backordering[13] of supplies and pharmaceuticals for future delivery.

This condition was caused because a primarily push-based[14] resupply/sustainment process for Class VIII was in place within the ANA and MoD Decree 4.0 backordering processes were not implemented.

There are multiple effects of not recording unfilled demands. Primarily, this situation created problems building true requirements for system-wide Class VIII forecasts. Additionally, RMHs, FSDs and even Corps-level units' actual Class VIII needs were rarely met. Finally, a general state of confusion was created because customers at lower levels may assume orders were going to be filled when in fact they were not.

Applicable Criteria

MoD Decree 4.0 "Supported and Supporting Unit Logistics Policy and Support Procedures," January 2009 Section 2-1 identified Planning as a logistics function which is "based on standard consumption data and policies to meet annual and operational requirements…." Section 7-3 specifies the form must be returned if a request is denied.

DoD 4140.1-R "DoD Supply Chain Materiel Management Regulation," May 23, 2003 Section C5.3 speaks to the requisitioning process, noting "Supply sources shall provide timely status information for each requisition…" The section also speaks to the need to confirm issues to the item property record; note a materiel denial if insufficient quantities are on hand to meet a request. Section C5.7 speaks to item accountability and notes "The storage activity is responsible for the content, changes, and accuracy of the inventory held under its control."

Discussion

Effective logistics processes require synchronicity between customers and suppliers regarding what was ordered, what was filled, and what was not filled for each submitted MoD Form 14. It was expected by customers (when they elected to backorder) that unfilled demands were recorded by the supplier for future completion when stock became available. As discussed in Observation 9, MoD Form 14 receipts were not acknowledged nor returned when denials of requests were decided.

[13] Decree 4.0 defines a backorder as 'That portion of requested stock not immediately available for issue." The decree specifies procedures for recording backorders for future supply issuances.

[14] The MoD operates a system of sending materiel—requested or not—to FSDs and lower level units, as opposed to responding to requests for supplies i.e. a demand-based process.

RMH customers have lost confidence in the ability of the FSDs and National Depot to follow-through on backorders. Hence, they often ordered only what they knew was available rather than what was needed. Thus, any forecasting of medical supply needs was based on skewed demand data.

A responsive supply system based on actual requirements requires that all of the demands are captured - whether or not the need is filled. A historical based system for identifying requirements can be effective only if it is supplemented with information on those needs that are going unmet. By tracking and recording unfilled demands, more reliable requirements based supply stock decisions may be made for supply need forecasting.

Recommendations

10a. NTM-A/CSTC-A mentor OTSG to create an RMH-level control mechanism to ensure unfilled demands are recorded and tracked at that level.

10b. NTM-A/CSTC-A partner with MoD LOGCOM to ensure MoD Decree 4.0 and related guidance pertaining to tracking supply requests are followed by the Medical FSDs and the National Depot now under MoD LOGCOM.

Management Comments

NTM-A/CSTC-A concurred with Recommendations 10a and 10b with the following response.

Recommendation 10a. MoD Form 2, as stated in answer to question 3b and 4c, is used to record the remaining balance on a MoD Form 14 that is not currently available through the supply system. MoD Form 2 provides a record of requests/demands and turn-ins. This is a basis to audit for materiel accountability, distribution for arriving materiel due-in, and a means to periodically validate due-in demands with each supporting depot. Mentors assist mentees at the RMH-level to properly use the MoD Form 2.

Recommendation 10b. Mentors at each FSD help the medical ANA soldiers at the Class VIII warehouse use MoD Decree 4.0 and related guidance pertaining to tracking supply requests through the following: training sessions, Mobile Training Teams, the Validation Team, and everyday oversight of mentee actions. Additionally, the FSD mentors ensure that the mentees are kept informed of changes to MoD Decrees and receive copies in Dari of all guidance.

Our Response

NTM-A/CSTC-A comments were responsive. No further comments are required.

PART II – ACCOUNTABILITY AND CONTROL MECHANISMS

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Accountability and Control Mechanisms

Background

In order to develop the medical support needed to allow the ANA and ANP to transition to self sustaining security forces, the NTM-A/CSTC-A Commanding General set a goal of accelerating development of U.S. and ANSF systems for supplying U.S. procured pharmaceuticals, medical supplies and equipment (Class VIII). To help achieve that goal, on November 10, 2010, he requested that the DODIG assist by examining U.S. and ANSF acquisition, distribution, storage, accountability and controls regarding medical equipment and supplies, particularly pharmaceuticals. On November 16, 2010, we announced an assessment to determine whether U.S. Department of Defense efforts to develop medical logistics systems for the ANSF were effective; and whether accountability and control of funding, acquisition, receipt, storage, and distribution of Class VIII supplies (primarily pharmaceuticals) given to the ANSF by the U.S or Coalition Forces was adequate.

What We Did

Our assessment teams simultaneously traveled to multiple sites throughout Afghanistan to examine the various aspects of our stated objectives. We reviewed appropriate records, including numerous reports, U.S. and ANSF policy documents, contracts, and other relevant electronic or printed records. We also interviewed senior U.S. officials and military officers, as well as senior ANSF mentored officials responsible for Class VIII supply chain management. We observed and photographed logistics and field operations and conducted spot checks of physical "inventory on hand," as compared to inventory records, when such records were available. Because all necessary depot inventory records did not exist or were not readily available, we could not conduct a more comprehensive examination. Nonetheless, we believe the assessment procedures we applied provided a reasonable basis for our conclusions.

Our assessment teams traveled throughout Afghanistan to meet with senior ANSF medical officials and their U.S. and Coalition Force mentors in order to assess the controls over pharmaceuticals, medical supplies, and medical equipment. Here are assessment team members being transported by a U.S. force protection detail in a Mine Resistant Ambush Protected (MRAP) vehicle near Herat, Afghanistan, December 11, 2010.

What We Found

As highlighted by observations 11 through 15, NTM-A/CSTC-A, in coordination with MoD, had not succeeded in developing a system of accountability and control over the funding, acquisition, receipt, storage, and distribution of Class VIII supplies (primarily pharmaceuticals) provided to the ANSF by the U.S. Government or other Coalition Forces. For example, responsible MoD officials or ANA managers:

- Had not adequately developed or issued the controls, policies, directives, or operating manuals needed to enable people to perform their duties.
- Had not properly maintained usage data on pharmaceuticals, supplies, or equipment as a basis for setting accurate requirements to make acquisitions.
- Did not always have contract, supporting documents, or other procurement files readily available for examination.
- Maintained contract and other procurement files that were incomplete or had inaccurate or duplicated data
- Improperly managed warehouse inventory records such as receiving, distribution, and "stock on hand" files, as evidenced by documents that were routinely unavailable, missing, or inaccurate.
- Did not remove expired pharmaceuticals, unneeded inventory, or counterfeit inventory from stock.
- Maintained warehouses and other storage facilities for pharmaceuticals, supplies, and equipment that were not secure or well organized, and were accessible by unauthorized personnel.

A new Class VIII Inventory Warehouse under construction near the National Military Hospital, Kabul Afghanistan, December 6, 2010. The existing Class VIII warehouse is the green building to the rear. The existing warehouse was poorly lit, not well organized, and did not have "on-hand" pharmaceutical inventory arranged by location.

Summary

Because ANSF medical officials and logisticians did not properly establish requirements for procurements, or manage or account for Class VIII inventory in accordance with MoD policy, the United States and its Coalition partners have been purchasing inventory that was not needed. In addition, Class VIII inventory (primarily pharmaceuticals) provided to the ANSF by the U.S. Government or other Coalition Forces is at significant risk of theft, misappropriation, or other illegal acts. Lastly, the medication needed by medical care providers has not been consistently supplied or provided at all.

Observation 11: Controls over the receipt, storage, accountability, and distribution of pharmaceuticals and other Class VIII supplies were insufficient to prevent theft, misappropriation, unauthorized use, or improper distribution

The ANSF oversight of Class VIII supplies was insufficient to prevent abuse, waste, loss, or diversion.

This occurred because the ANSF system of accountability and control mechanisms for the acquisition, distribution, storage, and use of pharmaceuticals, medical supplies, and medical equipment did not effectively implement MoD and MoI oversight regulations.

As a consequence, there was no assurance that needed medical supplies would reach ANSF medical facilities and personnel, and be used for their intended health care purposes.

Applicable Criteria

Decree 4.0, Ministry of Defense, Office of the Assistant Minister of Acquisition, Technology, Logistics, "Supported and Supporting Unit Logistics Policy and Support Procedures," January 2009 The decree establishes logistics policy and procedures for the Afghanistan National Army (ANA) as a basis for introducing, modernizing and integrating the ANA logistical system with NATO military logistics doctrine. The decree does not apply to the Afghanistan National Police (ANP), but it is instructive because it is consistent with widely accepted or standard practice as reflected in such U.S. publications as the Government Accountability Office (GAO) "Standards for Internal Control in the Federal Government," November 1999, and DOD Instruction 5010.40, "Managers' Internal Control Program Procedures," July 29, 2010. The decree requires appropriate officials to develop, implement, and enforce detailed logistics management policy, processes, and procedures for all classes of supply, including Class VIII. It also assigns supply chain management and warehouse operations responsibility for such activities as:

- Developing authorized stockage lists (ASLs);
- Developing medical logistics requirements based on demand data;
- Maintaining accurate accounting and other records;
- Properly receiving, storing, securing, protecting, and distributing pharmaceuticals, medical supplies, and medical equipment;
- Conducting periodic inventory examinations to compare stock records to stock physically on hand.

Decree 4.2, Ministry of Defense, Office of the Assistant Minister of Acquisition, Technology, Logistics, "Materiel Accountability Policy and Procedures," January 2009 The decree establishes materiel accounting policies and procedures for the Afghanistan National Army. The decree does not apply to the Afghanistan National Police (ANP), but again is instructive because it is consistent with widely accepted or standard practice as reflected in the U.S. publications indicated above. The decree assigns responsibility to commanders at all levels

for supervising, controlling, maintaining, and conducting supply management functions, transactions, and procedures. The decree requires:

- Pharmaceuticals and other Class VIII materiel to be properly safeguarded and used;
- Property records and supporting documents that account for controlled drugs and other items which are easily pilfered or marketed in the bazaar;
- Inventory records that include identification data, gain, losses, and balances on hand.
- Periodic 100 percent inventories where all inventory is physically observed and counted.

Discussion

Inquiry of NTM-A/CSTC-A mentors and ANA officials indicated that pharmaceutical and other Class VIII receiving and issue reports (at the National Military Hospital (NMH); the ANA Class VIII warehouse co-located with the hospital; and the ANA LOG COM Class VIII warehouse located near the airport) did not exist or were not readily available. Spot checks of records at all ANA national and regional hospital locations and supporting depots indicated supplies were either significantly understated or overstated. Neither NTM-A/CSTC-A mentors nor their ANA counterparts were able to produce records documenting any previous periodic examinations of recorded inventory balances against stock physically on-hand.

Pharmaceutical inventory records at all ANA depots did not contain location of the supplies in the warehouse. Consequently, warehouse personnel relied on memory and could not be certain whether they could identify all on-hand inventories. In addition, expired drugs and known counterfeit morphine were improperly stored and comingled with current and authentic stock. As a result, patients were at risk through improper distribution of expired or counterfeit drugs.

Because responsible MoD and ANA officials did not manage or account effectively for Class VIII inventory in accordance with Decrees 4.0, and 4.2, pharmaceutical and other inventory were at significant risk of theft, misappropriation, or other illegal acts.

Records were more readily available at the ANP national hospital and ANP Class VIII warehouse; however the ANP records were determined to not be entirely accurate. "Stock on-hand" inventory records did not match actual Class VIII stored at warehouse locations reviewed by the team.

Additionally, the mentoring of ANSF counterparts at all levels of the medical logistics system regarding accountability and control measures could be improved. Mentors could be conducting and reporting their independent periodic assessments of all ANSF oversight measures for Class VIII stocks and their effectiveness. This would provide visibility of the status of oversight across the ANSF medical system to senior NTM-A/CSTC-A officials, and contribute to reducing diversion, loss or corruption.

Recommendation

11a. NTM-A/CSTC-A mentor MoD and ANA and MoI and ANP officials to establish and enforce standard controls over the receipt, storage, accountability, and distribution of pharmaceuticals and other Class VIII supplies in order to prevent theft, misappropriation, unauthorized use, or improper distribution. Ensure this includes regular independent MoD and MoI oversight inspections.

11b. ISAF direct NTM-A/CSTC-A and IJC medical mentors to regularly inspect the status of Class VIII oversight, and report results to the Commander, NTM-A/CSTC-A and Commander, IJC, as well as the ANA OTSG and ANP OTSG.

Management Comments

NTM-A/CSTC-A concurred with Recommendations 11a and 11b with the following response.

Recommendation 11a. Accountability was one of the primary reasons for the move of Class VIII from MEDCOM to LOGCOM. Unlike MEDCOM, which required little to no paperwork to issue out material, the Class VIII National Supply Depot requires a MoD Form 14 (for standard requisitions) or Push Letter (for initial fielding). The FSD also requires a MoD Form 14 to release materiel. When supplies are received a proper inventory is conducted. This change improved accountability while reducing theft, misappropriation, unauthorized use and improper distribution. The MoD and MoI IG also inspect regularly.

Recommendation 11b. LTAG mentors provide oversight as part of their daily mentoring at all levels. The Logistics Validation Team does an assessment quarterly. The MoD and MoI IG also inspect regularly.

ISAF concurred with Recommendation 11b without further comment.

Our Response

NTM-A/CSTC-A and ISAF comments were responsive. We request a copy of a representative and recent Logistic Validation Team quarterly assessment.

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Observation 12: Ministry of Defense Decrees 4.0 and 4.2 were not effectively implemented or enforced

Decrees 4.0 and 4.2 provide a framework for Class VIII supply chain management. However, the medical logistics supply chain is not functioning effectively because ANSF officials are not developing, implementing or enforcing the framework those decrees provide.

Applicable Criteria

Decree 4.0, Ministry of Defense, Office of the Assistant Minister of Acquisition, Technology, Logistics, "Supported and Supporting Unit Logistics Policy and Support Procedures," January 2009 The decree establishes logistics policy and procedures for the Afghanistan National Army (ANA) as a basis for introducing, modernizing and integrating the ANA logistical system with NATO military logistics doctrine. The decree does not apply to the Afghanistan National Police (ANP), but it is instructive because it is consistent with widely accepted or standard practice as reflected in such U.S. publications as the Government Accountability Office (GAO) "Standards for Internal Control in the Federal Government," November 1999, and DOD Instruction 5010.40, "Managers' Internal Control Program Procedures," July 29, 2010. The decree requires appropriate officials to develop, implement, and enforce detailed logistics management policy, processes, and procedures for all classes of supply, including Class VIII. It also assigns supply chain management and warehouse operations responsibility for such activities as:

- Developing authorized stockage lists (ASLs);
- Developing medical logistics requirements based on demand data;
- Maintaining accurate accounting and other records;
- Properly receiving, storing, securing, protecting, and distributing pharmaceuticals, medical supplies, and medical equipment;
- Conducting periodic inventory examinations to compare stock records to stock physically on hand.

Decree 4.2, Ministry of Defense, Office of the Assistant Minister of Acquisition, Technology, Logistics, "Materiel Accountability Policy and Procedures," January 2009 The decree establishes materiel accounting policies and procedures for the Afghanistan National Army. The decree does not apply to the Afghanistan National Police (ANP), but again is instructive because it is consistent with widely accepted or standard practice as reflected in the U.S. publications indicated above. The decree assigns responsibility to commanders at all levels for supervising, controlling, maintaining, and conducting supply management functions, transactions, and procedures. The decree requires:

- Pharmaceuticals and other Class VIII materiel to be properly safeguarded and used;
- Property records and supporting documents that account for controlled drugs and other items which are easily pilfered or marketed in the bazaar;
- Inventory records that include identification data, gain, losses, and balances on hand.
- Periodic 100 percent inventories where all inventory is physically observed and counted.

Discussion

Decrees 4.0 and 4.2 were not fully implemented or enforced because ANSF officials were not effectively communicating or overseeing their provisions. For example:

- Decree 4.0 stipulates that logistics officers at various levels will assist medical officers in developing medical logistics authorized stockage lists (ASLs) and requirements. The document further stipulates that officials will develop medical logistic requirements based on demand data. However, our interviews with ANSF officials and their U.S. mentors indicate that Class VIII requirements are not based on usage data; that needed data is not available, and that consequently, the supply chain is providing pharmaceuticals and other Class VIII materiel that is not needed.

- Decree 4.0 and Decree 4.2 collectively require that commanders and other officials at all levels maintain accurate inventory records that include information on gains, losses, and balances on hand, and that inventories be periodically examined to compare records to stock on hand. However, our interviews with ANSF officials, personnel, and U.S. mentors; as well as spot checks of physical inventory, indicate inventory records do not exist or are not readily available, that available records are not accurate, and that there were no records to document periodic inventory examination to compare records with stock on hand.

In general, poor ANSF Class VIII inventory management and accountability existed because officials had not developed local standard operating procedures (SOPs) or other detailed guidance on inventory control, supervision, or oversight. As a result, such documents do not exist, or are not readily available in forward supply depots or hospitals.

Recommendations

12. NTM-A/CSTC-A mentor MoD and ANA officials to define and promulgate standard operating procedures and other medical materiel control mechanisms to ensure compliance with existing inventory management and accountability policies specified by Decrees 4.0 and 4.2.

Management Comments

NTM-A/CSTC-A concurred with Recommendation 12 with the following response.

Recommendation 12. Mentors at each FSD help the MoD and ANA officials use MoD Decree 4.0 and 4.2 through training sessions, the Logistics Mobile Training Team, and everyday oversight of mentee actions. Additionally, the mentors ensure that the mentees stay informed of changes to MoD Decrees and receive copies in Dari of all guidance. Standard operating procedures are implemented, as necessary, at each level. While training was not achieved at the end user level, that is being corrected within each MTF as well as mandated for all mentors in "pre-employment" training.

Our Response

NTM-A/CSTC-A and ISAF comments were responsive. No further comments are required.

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Observation 13: NTM-A/CSTC-A did not have clear data visibility and accountability for medical logistics contracts and purchase costs

There was no single credible data source that centralized contracts and acquisition records/transactions that collectively captured all associated costs pertaining to medical material and equipment for the ANSF. This resulted from several factors:

- MTAG, the unit ultimately responsible for the stand up and sustainable operation of the ANA health care system, did not separately and adequately record and track contract acquisition activity for Class VIII materials and supplies.
- Contract activity and associated costs were processed by three responsible entities: the NTM-A/CSTC-A Security Assistance Office (pseudo-FMS)[15]; CENTCOM Contracting Command (C3) through its Kabul Regional Contracting Center (contracts using local or international vendors and U.S. funds); and the MoD AT&L (Afghan funds for acquisition of medical material and equipment).
- As a result, ANA medical logistics disjointed and fragmented contract support contributed to its limited efficiencies, poor accountability, and a lack of confidence with capturing transactional data.

Applicable Criteria

Memorandum for CSTC-A Staff Directors, "Executing Afghanistan Security Forces Fund (ASFF) Resources," March 22, 2010 The purpose of this policy is to establish procedures for executing the Afghanistan Security Forces Fund (ASFF). This policy is intended to both enable operational flexibility while simultaneously providing oversight to ensure transparency and fiscal accountability. The policy codifies the methods and procedures CSTC-A will use to apply ASFF resources to validated requirements in order to procure goods and services for generating and sustaining the ANSF.

Joint Publication 4-10, "Operational Contract Support." October 17, 2008 The publication establishes doctrine for planning, conducting, and assessing operational contract support integration and contractor management functions in support of joint operations. It provides standardized guidance and information related to integrating operational contract support and contractor management, defines and describes these two different, but directly related functions, and provides a basic discussion on contracting command and control organizational options.

The Combatant Commander Logistics Procurement Support Board (CLPSB) is established to ensure that contracting and other related logistics efforts are properly coordinated across the entire AOR. This board is normally chaired by a GCC J-4 representative and includes representatives from each Service component command, combat support agency, as well as other military and USG agencies or organizations concerned with contracting matters.

[15] Pseudo-FMS is the term used for acquisitions using standard security assistance procedures, but in the case of Afghanistan, using ASFF appropriated funds for procurements rather than host nation funds or U.S.-provided grants.

Discussion

To obtain a complete picture of all contracts and acquisition activity for medical items, it was necessary to obtain and combine information from all three contracting entities; as discussed above.

In response to a Request for Information on medical items acquisitions, including consumables, medications, and equipment, NTM-A/CTSC-A/MTAG provided a spreadsheet purportedly listing contract activity. However, this spreadsheet could not be relied upon as either a historical or current picture of Class VIII acquisitions for several reasons:

- Certain contract and cost data were duplicated up to 36 times creating $23.2 million in overstated costs.
- Pseudo-FMS contract costs were not fully captured, understating costs by $45.4 million.
- For FY 2007, 92 of the contract transactions did not have a valid contract identifier.

MTAG subsequently provided four spreadsheets delineating Medical Supply contracts in four categories: consumables, equipment, services, and construction. While these were an improvement over the one-size-fits-all spreadsheet, initially provided, there were still errors or anomalies:

- The total number of pseudo-FMS could not be determined because services contracts were listed as "Various" rather than by contract identifier.
- The total value of pseudo-FMS actions was calculated at about $32.5 million when data provided by the Security Assistance Office identified $76.4 million in total value of procurements.
- Thirty one actions with no valid contract identifier were listed with $9.9 million in total costs.

CENTCOM Contracting Command through its KRCC office maintains data on contracts processed for non-FMS acquisitions, tracking by type of purchase--service, commodity, or construction. For commodities, tracking does not take place for purchases over $100,000. KRCC officials offered to provide raw data on contract activity, but needed specific contract numbers in order to provide accurate total costs. As noted above, MTAG had information on acquisitions which did not include valid contract identifiers; thus, KRCC was unable to provide the team cost data for those contract actions they processed.

Current CSTC-A guidance on management of ASFF funds used to generate the ANSF and sustain the fielded force calls for:

> …a resource strategy with systems and processes that maintains accountability, transparency, allocates resources, and has the flexibility to meet operational requirements…[including] a clear audit trail for all decisions and actions…

According to MTAG, its responsibilities include:

- managing the medical budget for the ANSF
- managing ANSF healthcare infrastructure development

Accurate information on medical materiel and equipment acquisitions funded by the U.S. government is essential to meet these stated responsibilities. However, such information was not available and a centralized, accurate, auditable data source for medical acquisitions does not exist.

Recommendation

13a. NTM-A/CSTC-A develop a financial management process that captures ANSF medical logistics procurement costs and contracts.
13b. NTMA/CSTC-A use Commander Logistics Procurement Support Board (Ref Joint Publication 4-10, "Operational Contract Support," October 17, 2008) to ensure that contracting and other related logistics efforts are properly coordinated across the Combined Joint Operations Area-Afghanistan.

Management Comments

NTM-A/CSTC-A concurred with Recommendation 13a and 13b with the following response.

Recommendation 13a. A holistic capture of information is needed to efficiently and effectively procure/contract pharmaceuticals, vaccines and medical supplies. CSTC-A is pursuing procurements from several means to include foreign military financing (FMF), foreign military sales (FMS), pseudo-FMS, direct funding, and local procurements.

Recommendation 13b. USFOR-A / CCC facilitates the Interagency Combined Joint Logistics Procurement Support Board (I+6). NTM-A/CSTC-A will ask the I+6 Logistics Procurement Support Board to have a Medical Logistics review.

Our Response

NTM-A/CSTC-A comments were responsive. We request additional detail on the actions being taken for the "holistic capture of information" that captures ANSF medical logistics procurement costs and contracts. We also request updates on the request for a Medical Logistics review by the I+6 Logistics Procurement Support Board and any subsequent deliberations by the Board.

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Observation 14: Excess Class VIII Medical Logistics Stocks and Equipment are prevalent throughout the system with no evident plan for periodic supply redistribution or disposition

Across the ANA health care system (HCS), excess equipment and supplies exist at all levels. There is no apparent plan for the ANA OTSG, with NTM-A/CSTC-A mentoring, to facilitate redistribution, disposition or destruction. Hundreds of serviceable pieces of equipment are sitting in warehouses that could possibly be used elsewhere, but no single source has full visibility of Class VIII inventory.

The excess equipment and supplies buildup throughout the ANA was caused by poor requirements generation processes, a "push" supply chain, the general ANSF habit of hoarding, weak oversight by MoD OTSG, and lack of centralized inventory visibility. Additionally, a general state of confusion regarding MoD Decree 4.0 applicability regarding excess stock disposition existed.

Excess items in a supply chain clog warehouses and distribution channels. Additionally, lack of visibility in a central data base prevents redistribution to units who have a need for the excess items.

Applicable Criteria

Decree 4.0, Ministry of Defense, Office of the Assistant Minister of Acquisition, Technology, Logistics, "Supported and Supporting Unit Logistics Policy and Support Procedures," January 2009 The decree establishes logistics policy and procedures for the ANA as a basis for introducing, modernizing and integrating the ANA logistical system with NATO military logistics doctrine. It is consistent with widely accepted practice as reflected in such U.S. publications as the Government Accountability Office (GAO) "Standards for Internal Control in the Federal Government," November 1999, and DOD Instruction 5010.40, "Managers' Internal Control Program Procedures," July 29, 2010. It established procedures for the identification, redistribution, and disposal of excess supplies and equipment, including pharmaceuticals and other Class VIII materiel. The Decree explains;

- Authorized materiel is established by what a unit reasonably needs to accomplish its mission.
- Excess is any materiel over and above that which is authorized.
- Units should not accumulate materiel in excess of total authorization and should turn-in any excess quantities on hand.
- Stock control includes the process by which officials' record and account for materiel disposal.

Decree 4.2, Ministry of Defense, Office of the Assistant Minister of Acquisition, Technology, Logistics, "Materiel Accountability Policy and Procedures," January 2009 The decree establishes materiel accounting policies and procedures for the ANA. It is consistent with widely accepted practice as reflected in such U.S. publications as the Government Accountability Office (GAO) "Standards for Internal Control in the Federal Government," November 1999, and DOD Instruction 5010.40, "Managers' Internal Control

Program Procedures," July 29, 2010. It also assigns responsibility to commanders at all levels for supervising, controlling, maintaining, and conducting supply management functions, including the identification, redistribution, and disposal of excess supplies and equipment including Class VIII materiel. The decree:

- Stipulated that commanders at all levels were responsible for turn-in of excess materiel.
- Established procedures for documenting excess supplies and equipment disposal, and removing that materiel from property records.

Ministry of Defense, Office of the Surgeon General, "MEDCOM Policy for the Destruction of Expired Medication," December 10, 2010 The policy applies to the ANA and establishes procedures for the identification and disposal of expired drugs. It requires medical facility commanders to:

- Identify expired pharmaceuticals.
- Turn-in or destroy those drugs
- Ensure that the destruction of drugs is independently witnessed; that the destruction is properly recorded; and that relevant documents are properly retained

Discussion

The supply requirements of RMHs and FSDs were not always sought directly. This "push" supply system, without adequate customer input, led to unneeded supplies and pharmaceuticals beings shipped, causing quantities of excess materiel to grow over time. Additionally, no centralized data base oversight and visibility of inventories was available because Core IMS implementation was immature throughout the supply chain. This hampered OTSG and LOGCOM ability to understand the reality of supplies on hand and needs across the HCS.

At Mazar-e-Sharif and Herat, the FSDs had optometry equipment on the warehouse shelf, with no matching healthcare provider skill set at the supported RMH. Additionally, MTAG mentors at the Herat RMH explained their operating room tables were in disrepair and needed to be replaced. At the same time, the FSD supporting the NMH had six new operating room tables that were in stock, were not in use, and could have been transferred. Hence, with sufficient visibility of serviceable medical equipment, OTSG or LOGCOM could have redistributed these items to where they were needed.

The medical logistics system, especially for pharmaceuticals, had excess or expired stocks throughout. MoD policy requires disposal or destruction of expired medicine or excess Class VIII materiel; however, the policy was not well understood. Some FSD managers believed expired stocks could be destroyed with the Medical FSD Commander having two internal FSD witnesses. Other FSDs understood three external/disinterested witnesses were required.

In Herat, the RMH Commander called OTSG during our team's site visit to ask whether he could destroy some expired pharmaceuticals and was told he could not. In Kandahar, the Medical FSD Commander admitted he had the ability and authorization to destroy expired pharmaceuticals. However, when asked why he would not destroy expired – and completely useless – laboratory

reagents, he said he was waiting for OTSG to specifically authorize it or someone from Kabul to travel to Kandahar and witness the destruction.

Recommendations

14a. NTM-A/CSTC-A mentor OTSG to build a plan that captures RMH-level excess supplies and redistributes to other supporting FSDs.

14b. NTM-A/CSTC mentor OTSG to implement the Core Information Management System, including the centralized data base that identifies medical supplies in the ANA HCS depot system.

14c. NTM-A/CSTC-A mentor MoD to clarify and reinforce policy contained in Decree 4.0 regarding the disposal of excess and expired material.

Management Comments

NTM-A/CSTC-A concurred with Recommendation 14a, 14b, and 14c with the following response.

Recommendation 14a. Plans have already been established to move excess supplies from the regional depots to the Class VIII warehouse. The ANA has agreed to the plan, but getting them to follow through will be difficult because of cultural resistance to give anything up. NTM-A/CSTC-A is working with MoD to work through these cultural barriers with a retrograde of bed pans, an innocuous item with a low likelihood of theft or sensitivity to accusations of corruption, in Herat. This will assist with mapping the actual process as well as identifying the real points of friction and resistance to follow through.

Recommendation 14b. 1st FSD, 2nd FSD, 3rd FSD and 4th FSD utilize Core Inventory Management System (CORE-IMS) to varying degrees. Additionally, by the end of June 2011, logistics managers at the NMH will use CORE-IMS. The mentors at each logistics node provide oversight, training, and direction to the mentees to encourage use of the system.

Recommendation 14c. There is new language in Decree 4.0 outlining the steps to be followed for expired items. Plans have already been established to move excess supplies from the regional depots to the Class VIII warehouse. The ANA has agreed to the plan but getting them to follow through will be very difficult because of cultural resistance to give anything up.

Our Response

NTM-A/CSTC-A comments were responsive. We request a six month update on Recommendations 14a and 14c regarding the effectiveness of the ANA agreed plan for redistributing and/or disposing of excess and expired material.

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Observation 15: Lack of a standard ANA Class VIII warehousing plan

RMH pharmacy/medical logistic supplies were not warehoused according to any standardized plan. This same condition applied to warehouses at the regional FSD and National Depot-levels.

Lack of guidance from MoD OTSG has led to each warehouse being stocked and organized based on local staff guidance only. There was also a lack of training and education of logistics staffs at all levels related to warehouse stocking operations.

The effect of poorly organized warehouses was inaccurate inventories and unfilled customer orders because warehouse staffs were unable to know what they had or locate items on the shelf. This resulted in inaccurate Stock Record Accounts and Property Book records, negatively impacting the effectiveness of the entire supply chain.

Applicable Criteria

Decree 4.0, Ministry of National Defense, Office of the Assistant Minister of Acquisition, Technology, Logistics, "Supported and Supporting Unit Logistics Policy and Support Procedures," January 2009 This decree establishes logistics policy and procedures for the Afghanistan National Army (ANA) as a basis for introducing, modernizing and integrating the ANA logistical system with NATO military logistics doctrine. The decree is consistent with widely accepted practice as reflected in such U.S. publications as the Government Accountability Office (GAO) "Standards for Internal Control in the Federal Government," November 1999, and DOD Instruction 5010.40, "Managers' Internal Control Program Procedures," July 29, 2010. The decree requires appropriate officials to develop, implement, and enforce detailed logistics management policy, processes, and procedures for all classes of supply, including Class VIII. It also assigns responsibility for supply chain management and warehouse operations, including:

- Authorized stockage lists (ASLs);
- Medical logistics requirements based on demand data;
- Accurate record keeping and accounting;
- Pharmaceutical, medical supply, and medical equipment receiving, accounting, storing, securing, reporting and distribution;
- Periodic inventory examination to compare stock records to stock physically on hand.

Decree 4.2, Ministry of National Defense, Office of the Assistant Minister of Acquisition, Technology, Logistics, "Materiel Accountability Policy and Procedures," January 2009 This decree establishes materiel accounting policies and procedures for the Afghanistan National Army. It also assigns responsibility to commanders at all levels for supervising, controlling, maintaining, and conducting supply management functions, transactions, and procedures. The decree requires:

- Pharmaceuticals and other Class VIII materiel to be properly safeguarded and used;
- Property records and supporting documents to account for controlled drugs and other items easily pilfered or marketed in the bazaar;

- Inventory records that include identification data, gain, losses, and balances on hand.
- Periodic 100 percent inventories in which all inventory is physically observed and counted.

The decree also requires responsible commanders to safeguard pharmaceuticals and other Class VIII materiel; to ensure Class VIII materiel is properly cared for and used; and to keep accurate accounting records that allows auditors to track Class VIII materiel receipt and disposition.

Discussion

The ANA warehouse supporting the NMH did not have a standard warehousing plan, or any other inventory identification system that allowed warehouse personnel to locate stock on hand. Every FSD we visited had a different warehousing plan. Most FSDs had a basic location code scheme, but at each site, the location plans varied. For example, some FSDs located items by generic type (i.e., drugs together, IV products together, bandaging and gauze together), and others alphabetically or numerically. Consequently, Class VIII storage was haphazard and disorganized, with personnel relying on memory to find inventory. We observed orders denied – despite stock on-hand – because warehouse staff could not locate items.

Logistics staffs at the RMH and primarily, FSD-level lacked training in inventory management. Anecdotally, we heard from MTAG mentors that many warehouse personnel operated based on their first-hand memory of stock locations. Nonetheless, this was an unreliable system centralized in the memory of a few personnel. Supplies could not be readily found to fulfill MoD 14 supply requests. Moreover, their knowledge was not transferable to replacement staff.

Recommendations

15a. NTM-A/CSTC-A mentor OTSG to build a standard NMH and RMH warehousing plan.

15b. NTM-A/CSTC-A partner with LOGCOM to build a FSD and National Depot Class VIII warehousing plan.

15c. NTM-A/CSTC-A mentor LOGCOM and OTSG to periodically inspect implementation of these plans.

Management Comments

NTM-A/CSTC-A concurred with Recommendation 15a, 15b, and 15c with the following response.

Recommendation 15a. Either a draft or formalized SOP exists at each storage location at this time. Although each CLVIII storage facility is physically different, the mentors will work with the NMH and RMHs logistics leaders to standardize organization in similar matters (i.e.- by pharmaceuticals, consumables, and bulk items) for storage of Class VIII and to ensure the ANA at each location can locate stock easier and conduct better inventory management.

Recommendation 15b. As stated in Response 15a, either a draft or formalized SOP exists at each storage location at this time. Although each CLVIII storage facility is physically different, the mentors will work with the NMH and RMHs logistics leaders to standardize organization in similar matters (i.e.- by pharmaceuticals, consumables, and bulk items) for storage of Class VIII and to ensure the ANA at each location can locate stock easier and conduct better inventory management.

Recommendation 15c. NTM-AICSTC-A will periodically inspect implementation of these plans, as well as mentor the MoD to conduct inspections.

Our Response

NTM-A/CSTC-A comments were responsive. No further comments are required.

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PART III – COALITION MEDICAL MENTORING EFFORT

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Coalition Medical Mentoring Effort

Background

In order to develop the medical leadership and capacity to build ANA and ANP self sustaining medical support, the NTM-A/CSTC-A training command was tasked to mentor the ANA and ANP medical leadership and capacity building efforts at national level above the ANA Corps level. The ISAF Joint Command (IJC) combat command mentors the ANP and ANA with their Coalition forces at the Corps and below levels.[16] Both organizations provide medical mentors in teams consisting of U.S. and other Coalition doctors, nurses, medical specialists and medical support personnel from a range of disciplines and specialties and from all ranks. The NTM-A/CSTC-A personnel serve on medical mentor teams with Afghan counterparts at the ANA and ANP national and regional hospitals, medical warehouses, and institutes of medical learning in the principal cities of Kabul, Gardez, Kandahar, Herat, and Mazar-E-Sharif. The ISAF/IJC mentors work as embedded training teams with ANA and ANP units deployed at many locations throughout Afghanistan.

U.S. mentor reviewing documentation with Afghanistan National Army personnel at a Class VIII warehouse in Herat, Afghanistan, December 11, 2010.

[16] ANA Medical at above Corps includes: ANA Surgeon General, ANA Medical Command consisting of the Dawood National Military Hospital and its supply depot (Kabul), four regional hospitals and their supply depots (Gardez, Kandahar, Herat, and Mazar-E-Sharif), and the Armed Forces Academy of Medical Sciences, Allied Health Professions Institute, and Military Medical Institute

ANA Medical at Corps and below includes: Corps Surgeons, Garrison Clinics, Brigade Surgeons and staff, three battalion aid stations per combat brigade, one medical company and one medical platoon per Brigade Combat Service Support Battalion (201st Corp Kabul; 203rd Corps Gardez, 205th Corps Kandahar, 207th Corps Herat; 209th Corps Mazar-E-Sharif, 215th Corps Shindand); the 111th Division Kabul; a Special Operations Division, an Air Corps, and a Guard Brigade

The ANP Medical includes the ANP Surgeon General, ANP National Hospital, ANP National Medical Warehouse (Kabul) and the 303rd Regional Surgeon Mazar-E-Sharif; 404th Regional Surgeon Kandahar, 505th Regional Surgeon Gardez, and 606th Regional Surgeon Herat

What we did

The assessment team conducted interviews with the U.S. medical mentors and DOD Defense contractors in Kabul, Gardez, Kandahar, Herat, and Mazar-E-Sharif. We also met with ISAF, NTM-A/CSTC-A, and ISAF/IJC headquarters staff, and MoD personnel and their mentors. In addition, we interviewed selected personnel assigned to the Office of the Assistant Secretary of Defense for Health Affairs /TRICARE Management Activity (OASD (HA)/TMA); U.S. Joint Forces Command (JFCOM); U.S. Central Command (CENTCOM); U.S. Air Force Central (AFCENT), Air Combat Command; and the USAF Medical Operations Center. We also interviewed the Program Manager of the Afghanistan Healthcare Sector Reach Back Project at the Center for Disaster and Humanitarian Assistance Medicine (CDHAM), Uniformed Services University of the Health Sciences (USUHS).

U.S. mentors with Afghanistan National Army personnel in Mazar-E-Sharif, Afghanistan, December 5, 2010.

The assessment team reviewed documents relating to International Standards, International Professional Affiliations, Department of Defense Instructions, Joint Publications, Service Instructions, Campaign Plans, and Operational Orders, Standard Operating Procedures, and contractual documents.

In the field, our team reviewed the effectiveness of medical mentoring efforts to develop an ANA and ANP medical (Force Health Protection[17], Combat Health Support[18]) health care system (HCS)[19], that meets NTM-A/CSTC-A's defined 2014-16 end-state for ANSF Healthcare: A self-reliant, professionally led ANSF health Department which generates and sustains sufficient police and army medical personnel, infrastructure, and logistics capabilities, with accountable and effective health services that support the ANSF. In doing so, we discovered challenges that set conditions which hampered the establishment of a credible medical system.

[17] A Force Health Protection (FHP) system consists of total force health protection by integrating a) Human performance enhancement; b) Health surveillance, intelligence, and preventive medicine; c) Casualty management; d) Patient movement; e) Medical logistics and infrastructure support ; f) Command and control.

[18] A Combat Health Support (CHS) system is designed to provide health care to soldiers on the battlefield. The system provides a continuum of care, from the point of injury and/or forward line of own troops through successive echelons of care, to definitive and rehabilitative hospitals.

[19] HCS is used to describe an ANA and ANP health care system that is the appropriate blend of the Force Health Protection and Combat Health Support system concepts found in existing and accepted U.S. military medical doctrine.

What we found

The lack of developed, implemented, and enforced health care standards and a related medical mentoring model limited the ability of Coalition forces to plan for and execute a mentoring plan, and therefore to measure progress in developing medical leadership and establishing an enduring institutional ANSF medical capacity.

There was no evidence of an overarching joint, integrated ISAF-ANSF plan developed by the MoD, MoI, and MoPH that provided clear direction based on defined medical standards and which prioritized the medical mentoring effort, which hindered medical system development.

Current Coalition/U.S. medical mentor personnel are provided to NTM-A/CSTC-A from the Request-for-Forces (RFF), Joint Manning Document (JMD), and most strikingly from the Combined Joint Statement of Requirements (CJSOR) process. However, this provided only half the authorized mentors, which was insufficient to effectively carry out the mission to support the timely development of the ANSF medical system.

Medical mentors were mismatched with their roles and responsibilities. There was a lack of medical mentors with army-based medical doctrine experience assigned to key positions. Rank-mismatches between medical mentors and Afghan counterparts created mentoring difficulties. Specialized medical mentors were assigned to mentor positions that did not require their level of expertise. Medical mentors were assigned to mentor highly trained/highly qualified Afghans and therefore the mentoring was of questionable best value. Medical mentors reported their actual mentoring time was limited to approximately 20 hours per week due to lack of availability of Afghan medical personnel.

Afghan medical personnel actually assigned and present for duty were fewer than authorized in the Tashkil, and therefore insufficient to provide effective medical care to the ANA, especially at the Corps commands, or develop a sustainable health care system in the prescribed timeframe.

Pre-deployment training was not provided to U.S. medical mentors, and mentors did not receive in-country orientation and recurring management guidance during their tours, thus preventing medical mentors from performing their duties and responsibilities effectively.

Mentor lessons-learned were not being shared real-time across the MTAG mentoring spectrum and mentors were not being instructed to submit their lessons-learned to Joint Universal Lessons Learned (JULLS) system for use by future medical mentors.

What has been ongoing since our in-county assessment

DoDIG representatives in-country have continued to monitor ISAF, NTM-A/MTAG, and IJC progress in shaping the medical mentoring mission. Their efforts to enhance prospects for success in developing the ANSF medical system transition to sustainability include the following ongoing actions:

- Working with CURE International and the MoD and MoI to complete, promulgate and implement Standards of Care for the ANSF

- Standing up a joint ISAF-ANSF Operational Planning Team (OPT) to look at the entire MTAG mission regarding MTAG's efforts to develop the ANSF healthcare system in conjunction with the MoPH, MoD/ANA and MoD/ANP

- Identifying the appropriate numbers, skills, and seniority of mentors, as well as requesting appropriate pre-deployment training for medical mentors

- Preparing policy delineating the "Division of Responsibility" between NTM-A/CSTC-A and IJC for medical mentoring of the ANSF.

Observation 16: Lack of defined standards of medical care for ANA and ANP health care systems

The Afghan National Security Forces (ANSF) lacks clearly defined health care standards and therefore lack end state objectives for the Coalition mentoring development of the health care system.

This was because previous efforts by the U.S. interagency and international partners to define health care standards with the MoPH, MoD, and MoI that would apply to Afghan civilian and security force medical personnel and facilities did not succeed.

Consequently, without defined health care standards, it has not been possible to provide an appropriately resourced and focused medical mentoring capability, which has hampered HCS development.

Applicable Criteria

CSTC-A/NTM-A OPORD 09-137 Assigns Staff Troop to Task for SURG (MED ETT).

HQ ISAF/IJC Standard Operating Procedure 11146 ANSF Health Development, Corps and Below Establishes a program to guide ANSF Health Development at Corps and below.

International Committee of Military Medicine (ICCM) Ensures medical services personnel have the means to work together, using similar practices, in operations involving international cooperation.

Joint Commission International (JCI) Outlines standards and evaluation methods designed to provide quantifiable benchmarks for patient care quality and drive positive changes for clinical staff, patients and management.

M.C. 326/2 NATO Principles and Policies of Operational Medical Support Guides nations in developing compatible medical support concepts, plans, structures, and procedures.

DoD 6025.13 Medical Quality Assurance (MQA) in the Military Health Care System (MHS) Guides the MHS in maintaining active and effective organizational structures, management emphasis, and program activities to assure quality healthcare throughout the MHS.

DoD 6025.13-R Military Health Systems (MHS) Clinical Quality Assurance (CQA) Program Regulations Implements the policy guidance concerning quality assurance in the MHS.

Discussion

In 2006, the Afghan Ministry of Public Health (MoPH), in conjunction with the United States Agency for International Development (USAID), began the development of the Hospital Standards Manual (HSM) for Afghanistan. The vision for these standards was to provide a framework of basic hospital functions and to give guidance for MoPH hospital development and

improvement. The intent was for these standards to be adopted nationally in Afghanistan, to include the MoD and MoI for the army and police medical care systems.

Because of an apparent lack of interagency and Afghan consensus, the MoPH standards were not completed. Since 2006, five ANSF hospitals--four ANA and one ANP--have been built and equipped in order to provide improved access and higher quality health care to both the ANA and ANP. Yet, without medical/hospital standards, Coalition medical mentors have been without clear guidance as to what specific capabilities the ANA and ANP HCS were required to achieve through their mentoring efforts.

During this assessment, DoDIG personnel found no evidence that health care standards existed in codified Afghan laws, directives, ministerial decrees, or developed criteria for the ANA or ANP HCS. Neither were there established metrics or criteria, or the use of established metrics or criteria, to measure the medical mentoring progress made in developing the ANA and ANP HCS.

The team concluded that the lack of an identified "Standard of Care" has been and is the "root cause" of many of the current issues that restrain the Command's efforts to build a sustainable medical capacity for the ANSF. One of the keys is the need to specifically define what the standard of care will be, promulgate that standard throughout the ANA healthcare delivery system, and use the standard to create an oversight program.

Recently, ISAF/SG began to prepare a draft ANSF health care policy in conjunction with NTM-A/CSTC-A and IJC. The policy will require concurrence with the ANSF (MoD/ANA and MoI/ANP) for approval, and coordination with the Ministry of Public Health. Final approval will be required by the Afghan President. The estimated completion time for the draft policy is approximately June-August 2011.

In addition, NTM-A/CSTC-A previously awarded an approximately $1.57M contract with the NGO *CURE International* to establish Operational/Procedural standards for seven medical facilities: ANA National Military Hospital, the ANP Hospital-Kabul, National Director for Security Hospital, and four ANA Regional Hospitals.[20] This includes writing a comprehensive hospital standards manual for use by ANSF medical personnel at their facilities. The manual will provide standards for the different disciplines and departments within the hospitals, including but not limited to hospital administration, internal medicine, intensive care unit, facilities, emergency room, pathology, nursing, blood bank, and surgery.

Cure International is currently conducting hospital inspections of the ANA medical system beginning with the NMH. Upon the completion of these inspections, the contractor will review the results and modify the standards accordingly. It was reported by MTAG that the ANA OTSG approved the use of the Cure proposed standards at the recent Medical Leaders Conference in Kandahar; however there is no evidence that the Ministers (MoD and MoI) have yet officially supported this decision. Full support of these ministries for the adoption of medical

[20] The Statement of Work states: *Although the standards could potentially encompass all three categories of Hospital Standards, the completed standards will predominantly involve operational/procedural standards. The standards will likely need to also include a number of structural standards; the inclusion and development of clinical standards will be limited.*

standards uniformly applied across the ANSF hospital system is a prerequisite for the Coalition mentoring initiative to progress with the "holistic" approach required to develop a cohesive enduring ANSF medical capability. The end-state is for the “Cure Standards” to be the ANSF’s standards with the long range plan to integrate the healthcare for the ANP and ANA into a single ANSF healthcare system.

Recommendations

16. ISAF, in coordination with MoD, MoI, and the MoPH, develop and execute plans that result in the development, codification, implementation, and enforcement of health care standards for the ANA and ANP HCS that are uniformly applied by Coalition medical mentors.

Management Comments

ISAF provided the following response to Recommendation 16.

The ANSF are currently working with mentors to implement Tier One hospital standards as defined by CURE International by contract. Additionally, ISAF is working with JHPIEGO to examine quality standards that they have developed for MoPH health facilities ranging from small out-patient facilities to district hospitals (community hospitals) and with HHS (CDC) on Joint Commission Essentials, a minimum but meaningful and effective validated international hospital standard for resource constrained environments that MoPH is also reviewing. The ANSF will ultimately be responsible for the enforcement of these standards. Coalition medical mentors will utilize these standards as mentoring goals.

NTM-A/CSTC-A partially concurred with Recommendation 16 with the following response.

NTM-A/CSTC-A has the mission for institutional development within the ANA and the ANP medical systems. The development and execution of health care standards not only with the ANSF but also across the MoPH is already well under way. The CURE International standards are being implemented.

Our Response

ISAF and NMT-A/CSTC-A comments to Recommendation 16 were responsive. No further comments are required.

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Observation 17: Lack of operational planning for ANA medical leadership and institutional capacity development

ISAF and MoD did not have an implemented integrated operational plan to coordinate their joint efforts to build an effective ANA health care system.

This was because the necessity to have an overarching ISAF-ANA coherent and synchronized plan, given the complexity of medical mentoring countrywide, was not fully appreciated by previous CSTC-A medical leadership. This understanding did not develop over successive leadership tours, which were short-term.

Consequently, the lack of development plan(s) resulted in uncoordinated and inconsistent efforts to develop ANA medical leadership and institutional capability. Most policies and guidance were established by mentors at regional hospitals rather than jointly at national level by ISAF and the ANA; these mentors did not have operational plans to synchronize their medical mentor activities with those of Coalition mentors at Corps and below.

Applicable Criteria

Campaign Plan for the Development of Afghan National Military and Police Forces-Interim, 29 January 2008 Provides an overarching strategy for the development of the Afghan Security Forces, to include the MoD and Mol.

HQ ISAF/IJC Standard Operating Procedure 11146 ANSF Health Development, Corps and Below Establishes a program to guide ANSF Health Development at Corps and below

CSTC-A/NTM-A OPORD 09-137 Staff Troop to Task for SURG (MED ETT)

DoDI 6000.16 Military Health Support for Stability Operations Establishes policy, assigns responsibilities, and provides instruction for military health support of stability operations in accordance with authority DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD (P&R)),” June 23, 2008

Joint Publication 4-02 Doctrine for Health Services Support Delineates requirements and considerations for the health service support (HSS).

FM 8-10-1 Combat Health Support System Provides an overview of the combat health support (CHS) system designed to provide health care to soldiers on the battlefield; a continuum of care, from the point of injury and/or forward line of own troops through successive echelons of care, to definitive and rehabilitative hospitals.

Discussion

During the DODIG mission, U.S. military medical mentors could not demonstrate that they had knowledge of any medical system development plan upon which to base their mentoring activities. They agreed they needed to operate under one central combined plan and strategy with sufficient guidance for them to be able to implement that strategy. And, the strategy would

need to have a defined end-state with respect to medical standards. It was the consensus of the medical mentors that they have been operating virtually autonomously, that progress across all five ANA hospitals is uneven, and that the ANA HCS is not being built as a uniform synchronized system. Rather, they perceived the ANA HCS as having been developed in "stovepipes"--the National Military Hospital and four stand-alone Regional Military Hospitals.

The team found that the ANA medical mentoring responsibility was divided. Above Corps was the responsibility of NTM-A/CSTC-A while Corps and below was the responsibility of IJC. IJC expressed the following concern: "NTM-A/CSTC-A and IJC have clearly divided the battle space…however in the medical world, a 'division' of battle space between "above Corps" and "Corps and below" doesn't make all that much sense if the goal is to develop a system… there is going to be a lot more organizational coordination required."

Medical mentors at the four regional ANA hospitals agreed that most U.S. and Afghan policy and operational guidance had been developed at the local medical facility level. This was necessary since little or no guidance emanated from MoD, the ANA/OTSG, or from NTM-A/CSTC-A. They also reported that there were other obstacles with U.S. medical mentoring, which tended to be both insufficiently effective and short-term because:

- ANA medical guidance had not been directed to field medical staff; without that, U.S. mentoring generally did not have sufficient weight with Afghan counterparts on its own to be effective

- It was difficult to get ANA medical counterparts dedicated to the development of ANA HCS when major unaddressed personnel concerns such as living conditions, rotation policies, promotions, and separation from families remained major distractions

- NTM-A/CSTC-A mentoring locally developed policy had not been sustainable, usually lasting only as long as the medical mentor or medical mentor team's tour of between six to nine months in length

There was consensus among the medical mentors interviewed at all of the sites that a "start over" phenomena existed with the arrival of each new rotation of medical mentor personnel. The medical mentors attributed this to the lack of direction and established performance criteria conveyed by NTMA/CSTC-A, combined with the corresponding lack of guidance received by their Afghan counterparts.

The medical mentors agreed that they were "working in a vacuum." One of their primary concerns was the lack of recurring dialogue with NTM-A/CSTC-A. The mentors stated that scheduled conference calls were routinely not held by the NTM-A/CSTCA Surgeon. They attributed their requirement to have to "learn the same lessons over and over" to their lack of guidance.

The medical mentors expressed concern that the medical system that was being developed to support the ANA resembled a "civilian" healthcare system, not an ANA HCS. While the NTM-A/CSTC-A Surgeons' staff believed that the "concepts" of U.S. military medical doctrine were

understood by the MTAG headquarters staff, they had not been disseminated throughout the command to mentors. Moreover, these "concepts" were not understood by their respective ANA counterparts.

If the ANA HCS develops into a system closely resembling a civilian health care system, it will lack key elements of a military health care system, which goes beyond simply providing treatment. The ANA HCS system must be broader and include military medical activities including: screening personnel; medical, surgical, and dental treatment; preventive medicine, veterinary medicine, medical material and military pharmacy, military medical logistics to include evacuation of battle field casualties; and scientific and medical research.[21]

Medical mentors also expressed concern that their efforts to distribute "best practices" between mentors at the different ANA medical facilities had not been supported by NTM-A/CSTC-A and that recommendations for changes in mentoring practices developed at the local level were not "well received."

Medical mentors had not submitted "lessons learned" into the Joint Universal Lessons Learned System (JULLS) nor had they accessed JULLS at any time in regards to their current mission; actually only a few medical mentors were aware of JULLS.[22]

NTM-A/CSTC-A leadership expressed concern about the lack of reach-back capability. There was no repository of expertise or dedicated support that the forward deployed personnel could use to establish standards of care, draw on for technical expertise, or use for continuity of planning. The high rate of turnover, tours as short as six months, drove an extensive need to develop some type of reach back capability.

Recently, NTM-A/CSTC-A has defined its 2014-16 end-state for ANSF Healthcare: A self-reliant, professionally led ANSF health department which generates and sustains sufficient police and army medical personnel, infrastructure, and logistics capabilities, with accountable and effective health services that support the ANSF. In order to accomplish this goal NTM-A/CSTC-A realizes it needs to:

- Train Afghan trainers in: laboratory, radiology, physician assistants, biomedical equipment technicians, medical non-commissioned officer's corps, and combat medics
- Accelerate medical leadership development for the ANA and ANP OTSG and MoD and MoI
- Build literacy, vocational skills, and English language skills required for sustainable medical training
- Inculcate an ethos of stewardship in pharmacy, medical logistics, medical equipment, and most important of all, patient caring as highest level of stewardship

[21] In accordance with the International Committee of Military Medicine; Afghanistan is a member state of the ICMM.

[22] The Joint Universal Lessons Learned (JULLS) is a process established for the collection and dissemination of observations, lessons learned, and issues (O/L/I) generated by joint operations, exercises, training events, and other sources. JULLS applies to both the training and operational environments of the Armed Forces of the United States.

- Develop enduring institutions, systems, and enablers
- Develop a single ANSF Health Department

Recommendations

17a. ISAF, in coordination with MoD, MoI, and MoPH, develop and implement a joint, integrated plan for the development of a sustainable ANSF HCS system consistent with established medical standards.

17b. Under Secretary of Defense for Personnel and Readiness designate a reach-back partner institution for the Afghan Armed Forces Academy of Medical Sciences to include the "Research-to-Policy-to-Doctrine-to-Training-to-Execution" chain guidance.

17c. NTM-A/CSTC-A mentor the MoD and ANA/OTSG, and the MoI and ANP/ OTSG to ensure ANA/ANP medical support requirements are included in MoD and MoI campaign plans, and ANSF field planning and training.

17d. ISAF enable Coalition medical mentors to share "best practices" across ANSF medical facilities and with mentoring teams partnered with ANSF units, and also ensure U.S. mentors are able to effectively utilize JULLS "lessons learned" system.

Management Comments

ISAF concurred with Recommendation 17a with the following response.

Concur that there must be an overall GIRoA strategy for ANSF HCS. ISAF, NTM-A/CSTC-A and IJC will jointly develop a single, integrated campaign plan for the development of a sustainable ANSF Health Care System and ensure it is properly nested in the overall GIRoA strategy.

Assistant Secretary of Defense for Health Affairs replying for Under Secretary of Defense for Personnel and Readiness concurred with Recommendation 17b with the following response.

We agree with the recommendation as written. Assignment of a reach-back partner institution should take into account other issues raised within the report, namely the primacy of Army medical support doctrine in the development of the Afghan National Security Forces medical support capability. The designated organization should be appropriately funded for this new task, potentially with non-Defense Health Program (DHP) funds, due to the legal restrictions concerning the DHP.

NTM-A/CSTC-A concurred with Recommendation 17c with the following response.

Working with both headquarters elements on developing robust and sustainable medical planning and operations capability. Both OTSG (ANP) and MEDCOM (ANA) have been asked to supply an ANA medical officer to work with NTM-A/CSTC-A and IJC in these arenas. We

expect to have a, fully joint effort by the end of May 2011. This team is actively reviewing requirements and fielding, as well as training.

ISAF and NTM-A/CSTC-A concurred with recommendation 17d with the following response submitted by NTM-A/CSTC-A.

Please see response # 19c; NTM-A/CSTC-A is already working with Center for Anny Lessons Learned which has integrated capability with JULLS. In addition, IJC and NTM-A/CSTC-A have partnered two operations officers to perform site visits to each Region/Zone, work with all ANSF mentor teams, and assess the best way forward for both Above and Below Corps mentoring assets.

Our Response

ISAF comments to Recommendation 17a were responsive. We request that a copy of the integrated campaign plan for the development of a sustainable ANSF Health Care System be forward when completed.

Assistant Secretary of Defense for Health Affairs comments to Recommendation 17b were responsive. We request an update on efforts to designate a reach-back partner institution for the Afghan Armed Forces Academy of Medical Sciences. Please describe what actions you have taken or plan to take to accomplish the recommendation.

NMT-A/CSTC-A comments to 17c were responsive. No further comments are required.

ISAF and NTM-A/CSTC-A comments to 17d were responsive. No further comments are required.

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Observation 18: Lack of NTM-A/CSTC-A required medical mentor capability

The medical mentor program lacked sufficient capability to meet the challenges of developing ANA medical leadership and institutional capacity.

This was in part because a number of personnel assigned as medical mentors were mismatched with their roles and responsibilities:

- Insufficient U.S. medical mentors experienced with U.S. Army-based medical doctrine were assigned to key ANA/OTSG senior-level positions
- Rank-mismatches between mentors of lower rank and their Afghan counterparts created mentoring difficulties
- Specialized medical mentor personnel were being assigned in some cases to mentor positions that did not require their high level of expertise
- Some mentor personnel were assigned to highly trained/highly qualified Afghans who did not require mentoring assistance

In addition:

- Medical mentors reported their actual mentoring time was limited to approximately 20 hours per week due to lack of availability of Afghan medical personnel
- NTM-A/CSTC-A had a stated requirement for 309 medical mentor personnel but only 158 were assigned. The majority of the unfilled positions were supposed to be sourced by Combined Joint Statement of Requirements (CJSOR).[23]

Consequently, NTM-A/CSTC-A could not provide the mentoring capability required to effectively develop the ANA medical leadership and institutional capacity development.

Applicable Criteria

CSTC-A/NTM-A OPORD 09-137 This OPORD provides Staff Troop to Task for NTM-A/CSTC-A Surgeon.

HQ ISAF/IJC Standard Operating Procedure 11146 ANSF Health Development, Corps and Below Establishes a program to guide ANSF Health Development at Corps and below.

Joint Publication 4-02 Doctrine for Health Services Support Delineates requirements and considerations for the health service support (HSS).

[23] The medical mentor personnel described and discussed in this observation is the mentor demographics provided by NTM-A/CSTC-A at the time they received the Request-for-Information. Mentor demographics vary over time but not significantly enough to alter these observations

Field Manual 4-0 Combat Service Support Army combat service support (CSS) doctrine as part of the national-theater CSS system, supports full spectrum operations.

Field Manual 4-02-1 Combat Health Logistics The field manual describes the Combat Health Logistics support of a Force Projection Army.

Field Manual 4-02.4 Medical Platoon Leaders Handbook Provides information on the structure and operation of all medical platoons and medical sections that are organic to combat and combat support battalions and squadrons.

Field Manual 4-02.6 The Medical Company, Tactics, Techniques, and Procedures Provides information on the employment, functions, and operations of divisional and non-divisional medical companies.

Field Manual 4-02.06 (FM 8-10-1) Provides information on the employment, functions, and operations of divisional and non-divisional medical companies and Army divisions

Field Manual 4-02.21 Divisional Brigade Surgeons Handbook Provides information on the structure and operation of the division and brigade headquarters medical staff.

Discussion

NTM-A/CSTC-A had the ability to influence change within their organization by adjusting the Request-for-Forces (RFF) and Joint Manning Document (JMD) to the mission; the correct medical mentor skills needed to be requested and the medical mentors requested needed to align with tactical-to-strategic Afghan counterparts. Medical mentoring efforts needed to be the correct balance between developing medical leadership and developing medical institutional capacity.

During the DODIG mission it was found that only nine of the total 131 NTM-A/CSTC-A U.S Army, Navy and Air Force medical mentors were U.S. Army personnel. Three were operations officers and NCOs on the NTM-A/CSTC-A staff and six were nurse and physician assistant instructors. The development of the ANA HCS requires medical mentoring based on medical support doctrine, tenets, and instruction comparable to that of the United States Army. It becomes a challenge for medical mentors to mentor doctrine, tenet, or instruction for the development of a land-based HCS if land-based doctrine is not one of their skill sets. Therefore, U.S. Army personnel should be targeted for those key positions in which development of ANA HCS doctrine, tenet, or instruction is mentored.

Medical mentor mismatches in rank between Coalition mentors and Afghan health care counter-parts were driving complaints from Afghan army medical personnel.

- NCOs were mentoring Afghan Officers; this ranged from mentoring doctors, dentists and pharmacists to mentoring Brigadier Generals

- Company Grade Officers were mentoring Field Grade Officer and Flag Officers ranging from Lieutenant Colonels to Major Generals

The personnel requests for medical mentors should be carefully aligned with actual needs when requesting medical mentors. The analysis of the NTM-A/CSTC-A mentoring roster indicated highly skilled medical providers were filling Joint Manning Document positions on the NTM-A/CSTC-A staff or mentoring Afghan counterparts with professions that did not require their skill level as mentors.[24] There were also instances of medical mentors being requested and assigned who had no Afghan counterpart to mentor.

Medical mentors at the national and regional hospitals expressed the same two concerns; either they were assigned to mentor a highly trained/highly qualified ("Afghan-Standard" was the qualifier in many cases), or they were assigned to mentor a doctor, nurse, or other medical professional who only held the title and was never trained, or was poorly trained, or learned only from on-the-job training (OJT).[25] Further, there were a high number of ANA Administrative and Ancillary personnel who had learned through on-the-job-training. The medical mentors expressed:

- If the Afghans are already trained and qualified, why do they need mentoring?
- If the Afghans are graduating/completing legitimate Afghan education programs but cannot operate even at the "Afghan-Standard" in support of the ANA or ANP…what consideration should be made to concentrate mentoring at the education-level as a way to develop medical force providers?"

The team identified these examples of mentor disconnects at the national and regional military hospitals:

- An ANA Pharmacist officer who completed Pharmacy School in Afghanistan was being mentored by an enlisted Pharmacy Technician
- An ANA Chief of Preventive Medicine/Chief of Internal Medicine, Internal Medicine Doctor who had graduated from a Medical School in Afghanistan was being mentored by an E-5 Preventive Medicine Technician
- A senior ANA hospital Director for Administration who had graduated from a Medical School in Afghanistan was being mentored by an inexperienced O-2 Healthcare Administrator who only had six months in the service
- An 0-4 Cardiologist-Internist (highly specialized U.S. Medical Provider) is a physician mentor at a Regional Military Hospital.

[24] The Joint Manning Document provides the baseline for JTF HQ staffing and is used for strength reporting, personnel accounting, awards eligibility determination, base support, and a host of other services and functions.
[25] No mentor could provide hard evidence of a doctor, nurse, or other medical professional who only held the title and was never trained – only anecdotal evidence.

U.S. medical mentors also were concerned that the actual average daily medical mentoring time with Afghan counterpart medical personnel was limited to no more than four hours, six days per week. This is approximately one half of a Full Time Equivalent (FTE)[26].

NTM-A/CSTC-A stated that their medical mentoring business model "…cannot succeed due to a 50% shortfall in personnel strength and limited training." The majority of the unfilled mentor requirements were from Combined Joint Statement of Requirements (CJSOR). In addition, the MTAG staff at NTM-A/CSTC-A headquarters had less than 50% of their authorized personnel.

Recommendations

18a. ISAF, in coordination with MoD/ANA, assess Coalition medical mentor personnel needs based on specific ANA medical standards, once defined, and a corresponding ANA medical system development plan.

18b. NTM-A/CSTC-A review U.S. medical mentor RFF and JMD requests to ensure U.S. medical mentors will be appropriate for assignment to Afghan medical counterparts in terms of corresponding rank, previous medical training, and experience.

18c. NTM-A/CSTC-A, in coordination with MoD, identify the causes for the limited time spent per day mentoring Afghan medical counterparts in the ANA hospital system and implement appropriate adjustments to enhance mentoring effectiveness.

18d. ISAF request U.S. Army personnel only for assignment to key positions in which development of ANA HCS doctrine, tenet, or instruction is mentored. Recommend designating these key positions as "U.S. ARMY ONLY" - "NO SERVICE SUBSTITUTION ALLOWED."[27]

Management Comments

NTM-A/CSTC-A concurred with Recommendation 18a with the following response.

Current mentor positions at Echelons Above Corps, MOD and MOL medical system are driven by demonstrated needs in regards to clinical skill set, administration, preventive medicine and support services (facilities, logistics and biomedical maintenance). Planning is guided by the 2014 transition goal, the development of the Tier 1 Afghan healthcare standards, and maturing concepts on how to effectively mentor. Our requirements for medical mentors will be provided to ISAF for review and approval. ISAF concurred noting that they will review and approve these requirements.

[26] Full-time equivalent (FTE) is a way to measure a worker's involvement in a project. An FTE of 1.0 means that the person is equivalent to a full-time worker; while an FTE of 0.5 signals that the worker is only equivalent to a half-time worker.

[27] In accordance with Global Force Management (GFM) Business Rules, it is the COCOM's prerogative to define and designate RFF requirements. The COCOM, in this case CENTCOM, defines and designates the skill-set and Service(s) required associated with each RFF position. JFCOM, as the Global Force Provider, defaults to the RFF skill-set and Service(s) required defined and designated by the COCOM. If skill-set and/or Service(s) required cannot be filled, JFCOM will negotiate an acceptable skill-set and/or Service(s) provider with the Services and COCOM so that the position can be sourced.

NTM-A/CSTC-A concurred with Recommendation 18b with the following response.

The JMD, RFF, and CJSOR are the focus of continual review. The formal review process will conclude at the end of May after a Requirements Council which will finalize the planning for all of these positions through 2014 and an evaluation of any identified enduring missions. By June 2011 all position descriptions will be rewritten.

NTM-A/CSTC-A concurred with Recommendation 18c with the following response.

One of the greatest challenges at NMH is staff absenteeism. NTM-A/CSTC-A continues to apply pressure at key leadership levels throughout the ANA medical system and MOD to address this chronic problem of accountability.

NTM-A/CSTC-A partially concurred with Recommendation 18d. ISAF did not concur. Their responses follow.

NTM-A/CSTC-A. MTAG works closely with IJC, who are predominantly US Army personnel. This cross fertilization of knowledge and experience allows NTM-A/CSTC-A to implement US Army regulations and policy through Navy and Air Force officers who are more than capable in mentoring standards of health care and overarching leadership principles.

ISAF. It is true that the present design is based on U.S. Army Medical Department however, it is not felt that this recommendation is necessary, particularly because there are current plans to have mentors from other Coalition countries and it will be advantageous to have them.

Our Response

ISAF and NTM-A/CSTC-A comments to 18a were responsive. No further comments are required.

NTM-A/CSTC-A comments to 18b and 18c were responsive. No further comments are required.

Based on NTM-A/CSTC-A and ISAF responses to 18d we believe that the general intent of the recommendation is being realized due to the predominance of Army personnel serving at IJC and working with MTAG. No further comments are required.

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Observation 19: Pre-deployment training and in-country orientation did not effectively prepare medical mentors.

Pre-deployment training for NTM-A/CSTC-A MTAG personnel presented at four different CONUS training bases is not focused on the medical advisory training mission. Moreover, upon arrival in-country, most mentors did not receive initial management orientation or continuing guidance during their tours.

This occurred because:

- No medical mentoring-specific training has been built into any pre-deployment course
- There was not a program to provide adequate in-country orientation or follow-up guidance and supervision

NOTE: There has been virtually no change to the medical mentor support shortcomings with respect to pre-deployment preparation and in-country guidance reported as a result of our last assessment visit in March 2009.[28]

Consequently, the medical mentors were not effectively prepared to understand and assume their duties and responsibilities, which contributed to sub-optimum performance and a negative impact on medical mentor personnel morale.

Applicable Criteria

Handbook 09-27 Chapter 14, Afghanistan Security Forces Funds This chapter explains Congressional limitations to the Afghanistan Security Forces Funds.

Global Force Management Business Rules Coordinates the Military Services policies and guidance while providing oversight for the allocation of forces.

Discussion

Pre-Deployment Training

NTM-A/CSTC-A medical mentors at the National Military Hospital and all four ANA regional hospitals reported that their pre-deployment training did not include a medical-specific program of instruction for medical mentors. Only a few medical mentors thought they were able to accomplish their medical mentoring mission by relying just on specialty skills and knowledge gained at their previous home-stations.

The NTM-A/CSTC-A Surgeon reported that the pre-deployment medical mentor training had once been presented using Afghanistan Security Forces Funds (ASFF) through the Center for Disaster and Humanitarian Assistance Medicine (CDHAM) Afghan Reach Back Project. This fledgling initiative consisted of training provided to a Provincial Reconstruction Team (PRT)

[28] SPO report: "Assessment of U.S. and Coalition Efforts to Develop the Medical Sustainment Capability of the Afghan National Security Forces" dated 10 March 2010.

attending pre-deployment training at Fort Bragg, North Carolina, and another presented at the basic pre-deployment training course at Fort Riley, Kansas.

These efforts had to be terminated after they were judged to be an inappropriate use of funding, per Handbook 09-27, Chapter 14: *"Afghanistan Security Forces Funds"*[29]. However, the NTM-A/CSTC-A Surgeon stated that there was a pressing need for medical specific pre-deployment training. He recommended this be presented according to a separate and specific Program of Instruction (POI), mandated for all Medical Training Advisory Group (MTAG) personnel regardless of mentors' military service or their sourcing.[30]

Additionally, as a separate initiative not related to NTM-A/CSTC-A, OASD/HA developed the Medical Stability Operations Course (MSOC) taught as a seminar as recent as February 2011 in San Antonio TX. The MSOC target audience was mid to senior level officers and NCOs preparing to deploy to a stability operation. The MSOC intent was pre-deployment training for medical personnel in the areas of stability operations, working with USAID, and cultural awareness. Currently, the MSOC is awaiting funding to convert the course from a seminar to an exportable course; possibly computer/web based.

The MTAG has medical mentors distributed across every region of Afghanistan. Essentially these mentors are required to mentor, advise, partner with, and train healthcare personnel during the provision of care to the sick or wounded in the battlefield, operating room, intensive care unit, hospital ward and to support the management of the healthcare system to include all logistics support.

There is no other NTM-A/CSTC-A mentoring/training requirement where the mentor finds him or herself in such close partnership with their Afghan counterpart during the performance of their duties. In addition, training becomes especially necessary given that mentors are generally not mobilized from training commands nor do they usually have prior experience.

To be effective, therefore, medical mentors need specific pre-deployment training which focuses on a range of key factors, among which are that:

- Healthcare in Afghanistan is delivered at a standard significantly below the standard mentors have been trained during their careers

- The technology gap that exists between the mentor's mission delivering of healthcare at a U.S. military medical center and the medical mentor's mission in Afghanistan requires they be prepared for this reality and be able to manage their expectations

- Addressing the moral dilemmas that can arise in the medical mentoring experience requires training in ethical evaluation, critical thinking/ethical construct role modeling.

[29] The reference specifically cites as unauthorized the use of funds for purchasing items or services used to support U.S. forces, even if their mission is to train the ANSF.
[30] NTM-A/CSTC-A states that there is a developed POI for Medical Mentor Pre-Deployment training but has not yet been able to provide the POI.

- Without understanding Afghan medical terminology specific to their counterparts, mentors cannot effectively communicate.

In-Country Orientation

Medical mentors indicated that they had not participated in any in-country orientation upon arriving in Afghanistan.

The operational leaders at each regional hospital as well as at the NMH believed that there had been insufficient planning, orientation, and follow-up support for their medical mentoring mission.

The NTM-A/CSTC-A Surgeon met with selected medical mentors leaders upon their arrival to Afghanistan. But, medical mentors could not articulate any specific guidance they had received applying to their individual mentoring mission and its objectives. Orientation, Policy and Guidance, and other mentoring tools that existed (e.g. the NTM-A/CSTC-A MTAG Mentoring Handbook) were not commonly known to the medical mentors or utilized during their deployment tours.

Recommendations

19a. Under Secretary of Defense for Personnel and Readiness designate the Army Medical Department (AMEDD) Center and School or similar institution to be the Center of Excellence for MTAG pre-deployment training with an approved program of instruction that is tailored for the mission in Afghanistan

19b. NTM-A/CSTC-A, in coordination with Commander, IJC, provide mandatory medical mentor orientation upon arrival in Afghanistan

19c. NTM-A/CSTC-A ensure medical mentors receive continuous management guidance and support during their tours consistent with the Medical Handbook and newly emerging mentoring requirements.

Management Comments

Assistant Secretary of Defense for Health Affairs replying for Under Secretary of Defense for Personnel and Readiness concurred with Recommendation 19a with the following response.

We concur with the recommendation as written. The designation by USD (P&R) of a service institution to be a, "Center of Excellence for Medical Training Advisory Group pre-deployment training," is a necessary first step to ensure fully trained and qualified service members fill the senior policy development mentoring positions with the Afghan National Security Forces. Additional efforts are needed to identify the unique aspects and expectations required for a successful medical mentoring program. These should be the basis of the measures of effectiveness that will be used to develop the appropriate training needed for pre-deployment as well as in-country training. An excellent starting point to develop this training is the Medical Stability Operations Course, developed by the Defense Medical Readiness Training Institute. It focuses on the medical aspects of stability operations to include working with the Interagency

partners and consideration of host nation language, culture and beliefs. It will cover many of the issues identified in the report.

NTM-A/CSTC-A concurred with Recommendation 19b with the following response.

At present, course content and the POI have been modified for pre-deployment and in country training requirements based on feedback from participants in the Pilot Group and Group 2. Contacts have been made with plans to create slide presentations with voice over to provide to pre-deployment training sites so that content delivery is consistent for Medical Team Mentors in CONUS. Approximately 12 hours of content should be delivered in CONUS with an additional 6 - 8 hours to be completed once the team members arrive in country. Revisions of the presentations as well as the POI are in progress. After pre-deployment modules are complete, this content will be exported to pre-deployment training sites for utilization. In - country specific content, such as wiring diagram, ANA medical logistics, and introduction to the MTAG staff, will still be taught here when new team members arrive. The primary challenge with respect to completing these presentations is media services to assist with voice over of the slide presentations.

NTM-A/CSTC-A concurred with Recommendation 19c with the following response.

All mentors as of 1 March 2011 now report directly to Kabul on entering country for a three day orientation and guidance session, then engage in ten days hand over training with their predecessor before beginning their jobs. They are assigned a team leader who manages their daily duties. Teams have weekly telephone conferences with the Deputy Surgeon, and Team Leaders send weekly War reports up to the CMD Surgeon's office. The Command Surgeon has engaged in two battlefield circulations with quarterly BFC planned to each site. The Chief Nurse has regularly engaged in BFCs, runs weekly VTCs with nurse mentors across Afghanistan, and is heavily engaged with all nurses at all levels on a regular basis. Subject matter experts such as the senior Radiologist, senior Lab officer and sale Physical Therapist engage in BFC to perform site assessments, conduct training, and offer guidance and assistance to mentors as well as local providers. When feasible, they are accompanied by their chief mentees as a form of train the trainer. All mentors now also depart from Kabul, and engage with CALL and the MTAG staff to archive lessons learned and TTPs.

Our Response

Assistant Secretary of Defense for Health Affairs comments to Recommendation 19a were responsive. We request an update on efforts to designate a service institution to be a Center of Excellence for Medical Training Advisory Group pre-deployment training. Please describe what actions you have taken or plan to take to accomplish the recommendation.

NTM-A/CSTC-A comments to Recommendation 19b were responsive. We request a copy of the POI once revisions are complete.

NTM-A/CSTC-A comments to Recommendation 19c were responsive. No further comments are required.

Observation 20: ANA Medical personnel shortages

The lack of assigned healthcare personnel significantly limits Coalition effort to provide effective ANA medical support and to jointly build with the MoD a sustainable ANA healthcare system.

This has resulted from the inability of the Afghan medical teaching institutions to recruit and graduate sufficient personnel to meet Tashkil authorizations. And, many of those personnel who are trained seek to avoid what they perceive as dangerous assignments away from their families.

As a result, ANA medical facilities outside of Kabul, the ANA regional hospitals and the medical facilities and functions below Corps, suffer from deficiencies in assigned medical personnel, especially physicians. This limited the medical services provided to Afghan soldiers, and is hampering development of an effective, sustainable ANA health care system.

Applicable Criteria

HQ ISAF/JC Standard Operating Procedure 11146 ANSF Health Development, Corps and Below The purpose of this SOP is to establish a program to guide ANSF Health Development for Corps and below.

Discussion

The medical system that is supposed to support the ANA has significant shortages of Afghan medical care at the regional hospitals and critical personnel deficiencies in the Afghan military Corps.

The problem originates with the inability to recruit and graduate enough medical care personnel and to ensure they are then put into their assigned positions. Recently, NTM-A/CSTC-A and the ANA OTSG have initiated actions to improve this situation beginning with a regional hiring program.

Meetings with Afghan Commanders and NTM-A/CSTC-A staff confirmed that medical provider availability is lacking throughout the ANA, especially outside of Kabul. Regional hospital commanders and Corps Commanders reported that they did not have sufficient medical personnel assigned to enable basic required medical care to be provided their soldier patients.

The 205 Corps Commander and Corps Surgeon stated, for example, that they were authorized 50 medical doctors (MD) yet had only two assigned. Moreover, the Corps Surgeon noted that only MDs could order and provide certain essential medications to their soldiers, which further underscores this medical logistics problem.

With respect to requirements and assignment of doctors, physician assistants, and nurses on the SY 1389 Tashkil[31] relating to the National Army Military Hospital, the four regional military hospitals and the Corps and their sub-commands indicates:

[31] SY 1389 Tashkil and assignment information provided by the ANA GS G-1 and was current as of 10 Oct 10.

Organization	Doctors of Medicine (MD)		
	Authorized MDs	MDs On Hand	Percentage of authorized MDs On Hand
NMH	171	136	79.5%
Regional Hospitals	140	78	55.7%
Corps and below	319	55	17.2%
Total	630	269	42.6%

Organization	Physician Assistants (PA)		
	Authorized PAs	PAs On Hand	Percentage of authorized PAs On Hand
NMH	0	41	Over Authorization
Regional Hospitals	116	29	25.0%
Corps and below	351	182	51.8%
Total	467	252	53.9%

Organization	Nurses		
	Authorized Nurses	Nurses On Hand	Percentage of authorized Nurses On Hand
NMH	157	81	51.5%
Regional Hospitals	116	29	25.0%
Corps and below	35	16	45.7%
Total	308	126	40.9%

The shortages in the number of medical providers actually assigned to ANA hospitals and combat units versus their defined needs and Tashkil authorizations has led to a unsustainable gap in the ability to provide necessary medical services support. In effect, the medical care that was supposed to be provided the ANA was not being provided. Additionally, without Afghan medical counterparts to mentor, the purpose for medical mentor assignment and the objectives of the medical mentoring program were being undermined. And, as a result, the Coalition and MoD may not be able to develop an effective and sustainable ANA HCS within an acceptable timeframe.

Recommendation

20. ISAF mentor the MoD to focus on all available opportunities for providing the ANA with qualified Afghan medical personnel to fill ANA Tashkil positions to a level acceptable to the MoD.

Management Comments

ISAF and NTM-A/CSTC-A concurred with Recommendation 20 with NTM-A/CSTC-A noting that the recommendation is best directed at the NTM-A/CSTC-A command. NTM-A/CSTC-A additionally responded as follows.

Significant partnered and focused effort to streamline the recruiting and accessions process is underway; the assessment period to measure effectiveness of these changes will provide initial data in May 2011.

Our Response

ISAF and NTM-A/CSTC-A responses to Recommendation 20 are responsive. We request that NTM-A/CSTC-A provide a status update on the results of the assessment period to measure effectiveness as well as any associated actions planned based on analysis of the assessment results.

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Appendix A. Scope and Methodology

We conducted this assessment from November 2010 to January 2011 in accordance with the standards published in the *Quality Standards for Inspections.* We planned and performed the assessment to obtain sufficient and appropriate evidence to provide a reasonable basis for our observations and conclusions based on our assessment objectives. Site visits in Afghanistan were conducted from November 30-December 16, 2010.

We reviewed DoD planning guidance as reflected in campaign plans, operational orders and fragmentary orders associated with the effort to develop medical logistics capability of the ANSF, MoD and MoI. We also reviewed NTM-A/CSTC-A Instructions and guidance as well as Decrees and guidance published by the Afghan MoD and MoI.

The purpose of our assessment in Afghanistan was to determine whether the system of accountability and control over funding, acquisition, receipt, storage and distribution of Class VIII supplies funded by, or provided to the ANSF by the DOD; specifically in the areas of pharmaceuticals, medical materiel, and equipment is sufficient.

We conducted meetings with NTM-A/CSTC-A staff and civilian contractor personnel and reviewed plans and policies pertinent to all aspects of developing medical logistics capacity for the ANSF. Our work focused on obtaining data including, but not limited to, the following areas:

- Planning as reflected in campaign plans, operational orders and fragmentary orders associated with the effort to develop medical logistics capability of the MoD and MoI
- Implementation by entities of the DoD, NATO/ISAF, Coalition forces, and the GIRoA to develop medical logistics system
- Procurement activities of Class VIII items and medical equipment associated with the MoD and MoI
- Issues pertaining to the performance and logistical readiness of MoD and MoI
- Ministry of Defense, Office of the Surgeon General, ANA Logistics Command, National ANA Military Hospital and five (5) Regional Hospitals and warehouses
- Ministry of Interior, ANP Surgeon General and the ANP National Hospitals and warehouse
- MoD and MoI orders and guidance associated with accountability and control over Class VIII supplies and medical materiel and equipment
- USGNATO/ISAF, and Coalition personnel/teams/units involved in the effort to develop institutional capacity for the MoD and MoI, to include units/organizations in the "partnering" effort
- Prior assessments, audits, inspections, and studies

Office Calls and Briefings: We met with DOD and ANSF organizations and individuals located throughout Afghanistan for this assessment. The itinerary included meetings with:

- HQ ISAF CJMED
- NTM-A/CSTC-A
  - Commander, NTM-A/CSTC-A
  - NTM-A/CSTC-A Staff including
    - IG, CJ-8, SAO
    - CORs and COTRs
    - M-TAG
  - Government Civilian Contractors (MPRI/DynCorp and others involved in the capacity-building effort)
- MoD/ANA
  - Minister of Defense
  - Chief of the General Staff, ANA
  - Director Office of the Surgeon General (OTSG)
  - Director for the Logistics Command Class VIII at Depot 0
  - Military leaders and soldiers in the field as appropriate
- MoI/ANP
  Minister of Interior
  - ANP Surgeon General
  - Police leaders in the field as appropriate

Site Visits: To gain additional knowledge, two site visit teams conducted simultaneous visits of medical facilities and associated logistic depots as follows:

- National Military Hospital, Kabul
- 203 Corps, Gardez (Conference Call)
- 205 Corps, Kandahar
- 207 Corps, Herat
- 209 Corps, Mazar-e-Sharif
- Wazar-Akbar-Khan Hospital, Kabul (Ministry of Public Health)
- National Police Hospital, Kabul

Limitations

Security considerations prevented a formal site visit to the Gardez, Afghanistan area.

Use of Computer-Processed Data

We reviewed computer generated data to identify medical logistic contracts to determine number, type and associated costs of medical equipment and supplies purchased in support of the

ANSF healthcare system. We judged the information to be sufficiently reliable to support the conclusions and recommendations in the report.

Use of Technical Assistance

Two subject matter experts were used during the conduct of this assessment. A senior United States Army, Medical Service Corps Pharmacist and on temporary assignment and a senior United States Air Force Medical Service Corp Health Care Administrator logistician on temporary assignment provided valuable insight and expertise during the conduct of this assessment.

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Appendix B. Summary of Prior Coverage

During the last three years, the DOD, the Government Accountability Office (GAO) and the Department of Defense Inspector General have issued a number of reports and testimony discussing the development, accountability and control of logistics and supplies for the ANSF.

Unrestricted DOD reports can be accessed over be Internet at http://www.defense.gov/pubs
Unrestricted GAO reports can be accessed over the Internet at http://www.gao.gov
Unrestricted DODIG reports can be accessed over the Internet at http://www.dodig.mil/audit/reports

Some of the prior coverage we used in preparing this report has included:

Congressionally Initiated Reports

Report to Congress in accordance with the 2008 National Defense Authorization Act (Section 1230, Public Law 110-181), "Report on Progress toward Security and Stability in Afghanistan," June 2009

Report to Congress in accordance with the 2008 National Defense Authorization Act (Section 1230, Public Law 110-181), as amended, "Report on Progress toward Security and Stability in Afghanistan," April 2010

Report to Congress in accordance with the 2008 National Defense Authorization Act (Section 1230, Public Law 110-181), as amended, "Report on Progress toward Security and Stability in Afghanistan," November 2010

Government Accountability Office

GAO-10-842T, "Preliminary Observations on DOD's Progress and Challenges in Distributing Supplies and Equipment to Afghanistan," June 2010.

GAO-10-655R, "Strategic Framework for U.S. Efforts in Afghanistan," June 2010

GAO-08-661, "Further Congressional Action May Be Needed to Ensure Completion of a Detailed Plan to Develop and Sustain Capable Afghan National Security Forces," June 18, 2008

Department of Defense Inspector General

DODIG Report No. SPO-2010-001, "Assessment of U.S. and Coalition Efforts to Develop the Medical Sustainment Capability of the Afghan National Security Forces," March 31, 2010

DODIG Report No. SPO-2009-007, "Assessment of U.S. and Coalition Plans to Train, Equip, and Field the Afghan National Security Forces," September 30, 2009

DODIG Report No. SPO-2009-001 – "Assessment of Arms, Ammunition, and Explosives Control and Accountability; Security Assistance; and Sustainment for the Afghan National Security Forces," October 24, 2008

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Appendix C. Organizations Contacted and Visited

We visited, contacted, or conducted interviews with officials (or former officials) from the following NATO, U.S., and Afghan organizations:

Afghanistan

ISAF

- HQ ISAF CJMED
- Regional Command North
- Regional Command South
- Regional Command West

Commander, NTM-A/CSTC-A

- Medical Training Advisory Group Staff
- CJ-8
- Logistic Training Advisory Staff
- Security Assistance Office
- CJ-Inspector General
- Criminal Investigation Division
- Defense Criminal Investigation Service
- DynCorp Contractor Program Manager
- Military Professional Resources Incorporated (MPRI) Contractor Program Director
- Commander Regional Support Command North
    - Medical Training Advisory Group staff
- Commander Regional Support Command South
    - Medical Training Advisory Group staff
- Commander Regional Support Command West
    - Medical Training Advisory Group staff

Government of the Islamic Republic of Afghanistan

Ministry of Defense

- Minister of Defense
- MoD Inspector General
- Office of the Surgeon General
- Chief of Logistics and Finance/Budget
- Commander National Military Hospital (Kabul)

Ministry of Interior

- Deputy Minister for Admin/Support
- MoI Inspector General

- Afghan National Police Deputy Surgeon General
- Afghan National Police Class VIII Warehouse (Kabul)
- Afghan National Police Hospital (Kabul)

Afghan National Army

- Chief of General Staff
- General Staff Inspector General
- Kabul Military Training Center
- Military Entrance Processing Station
- 203 Corps, Gardez (via phone)
    - Corps Surgeon, 203 Corps
- 205 Corps, Kandahar
    - Commander, 205 Corps
    - Corps G-4
    - Deputy Commander 205 Corps
    - Corps Surgeon
    - Personnel assigned to the Troop Medical Clinic
    - Commander and staff of the Regional Military Hospital
    - Commander and staff assigned to the Forward Support Depot
- 207 Corps, Herat
    - Commander, 207 Corps
    - Corps G-4
    - Deputy Corps Commander
    - Corps Surgeon
    - Personnel assigned to the Troop Medical Clinic
    - Commander and staff of the Regional Military Hospital
    - Commander and staff assigned to the Forward Support Depot
- 209 Corps, Mazar-e-Sharif
    - Commander, 209 Corps
    - Corps G-4
    - Corps Surgeon
    - Personnel assigned to the Troop Medical Clinic
    - Commander and staff assigned to the Regional Military Hospital
    - Commander and staff of the Forward Support Depot

United States

Department of Defense

- Under Secretary of Defense for Personnel and Readiness,
    - Officials assigned to the Assistant Secretary of Defense for Health Affairs

Department of the Army

- Officials assigned to the U.S. Army Medical Material Agency
    - Officials assigned to U.S. Army Medical Material Center, Europe

Department of the Air Force

- Officials assigned to the U.S. Air Force Medical Operations Center

Joint Forces Command

- Officials assigned to the U.S. Joint Forces Command (Surgeon General)

U.S. Central Command

- Officials assigned to the Office of Inspector General
- Officials assigned to the Office of the Surgeon General, U.S. Air Forces Central

U.S. Air Combat Command

- Officials assigned to the Office of the Surgeon General

Center for Disaster and Humanitarian Assistance Medicine

- Officials assigned to the Afghanistan Healthcare Sector Reach Back Project at the Uniformed Services University of the Health Sciences.

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Appendix D. Report Distribution

Office of the Secretary of Defense

Secretary of Defense
Deputy Secretary of Defense
Chairman of the Joint Chiefs of Staff
Under Secretary of Defense (Comptroller)/Chief Financial Officer
Deputy Chief Financial Officer
Deputy Comptroller (Program/Budget)
Under Secretary of Defense for Policy
Under Secretary of Defense for Personnel and Readiness*
Assistant Secretary of Defense (Health Affairs)

Combatant Commands

Commander, U.S. Central Command
Commander, International Security Assistance Force/U.S. Forces–Afghanistan*
    Commander, International Security Assistance Force Joint Command
    Commander, NATO Training Mission-Afghanistan/Combined Security Transition Command–Afghanistan*

Other Defense Organizations

Special Inspector General for Afghanistan Reconstruction

Congressional Committees and Subcommittees, Chairman and Ranking Minority Member

Senate Committee on Appropriations
    Senate Subcommittee on Defense
Senate Committee on Armed Services
Senate Committee on Homeland Security and Governmental Affairs
House Committee on Appropriations
    House Subcommittee on Defense
House Committee on Armed Services
House Committee on Oversight and Government Reform

* Recipient of the draft report

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Appendix E. Background – Afghan National Army and Police Health Care System

Background

Following three decades of war, the health care system in Afghanistan was undeveloped and did not meet any internationally recognized health care standard. After the fall of the Taliban in 2001, the US and international coalition forces developed a plan for creating a national security force that included a military health care system.

The military health care system in existence at the start of the coalition initiative consisted of remnants of the Russian-based system with multiple poorly-supported clinics, four small hospitals spread across the country, and the 400-bed Dawood National Military Hospital (NMH) which is the largest hospital in Afghanistan, located in Kabul.

These medical facilities provided the starting point for developing healthcare system capabilities for the ANA and ANP capable of providing health service support to Afghan Soldiers, Policemen and families of the ANA and ANP.

Major ANSF Organizations and Supporting Medical Elements

Afghan National Police

ANP Surgeon General and staff, and medical assets which include the Office of the Surgeon General and subordinate administrative offices, ANP Hospital, ANP Medical Warehouse, ANP training center clinics, and medics assigned to the border and civil order police.

Afghan National Army

The ANA Surgeon General and staff, the ANA Medical Command consisting of the Dawood NMH and four military regional hospitals (RMH), the Armed Forces Academy of Medical Sciences, and medical assets at Corps and below. Corps and below assets include Corps Surgeons, Garrison Clinics, Brigade Surgeons and staff, three battalion aid stations per combat brigade, one medical company and one medical platoon per Brigade Combat Service Support Battalion (Kandak is the Dari word for battalion).

The following sections describe how the ANA delivers healthcare:[32]

ANA Combat Health Support System Echelons of Care

The ANA Combat Health Support (CHS) system is described in terms of CHS Echelons of Care. CHS is arranged into four echelons of medical care. Each echelon reflects an increase in medical capabilities while retaining the capabilities found in the preceding echelon. The four echelons of support extend rearward from the battlefield and are tailored to enhance patient acquisition, treatment, evacuation and return to duty as far forward as the tactical situation permits.

[32]SPO fieldwork focused primarily on the ANA.

Echelon I

Medical care is provided by designated individuals or elements organic to combat and combat support units. Major emphasis is placed on those measures necessary to stabilize the patient (maintain airway, stop bleeding, and prevent shock) and allow for evacuation to the next echelon of care. Echelon I medical care is provided by the medical platoons of combat/combat service kandaks, medical companies of combat service support kandaks, and garrison troop medical clinics (TMC). Generally, this is the first medical care a soldier receives and should include the following:

- Immediate lifesaving measures
- Prevention and treatment of disease and non-battle injuries
- Combat operational stress control preventive measures
- Patient collection.
- Medical evacuation from supported units to supporting medical treatment elements.
- Treatment provided by designated trauma specialists or treatment squads (Kandak Aid Stations).

A major emphasis is placed on those measures necessary for the patient to return to duty (RTD), or to stabilize the patient to allow for evacuation to the next echelon of care. These measures should include maintaining the airway, stopping bleeding, preventing shock, protecting wounds, immobilizing fractures, and other emergency measures, as indicated.

Echelon II

Medical care at this echelon is rendered at the combat Brigade (BDE) level, by the Medical Company in the Brigade's Combat Service Support (CSS) Kandak. There are also Garrison TMCs that provide Echelon II care with limited laboratory assets.

At the medical company, patients are examined and wounds and general status are evaluated to determine the treatment and evacuation precedence, as a single casualty among other casualties. Those patients who can return to duty within 1 to 3 days are held for treatment.

Emergency medical treatment (including beginning resuscitation) is continued and, if necessary, additional emergency measures are instituted; but they do not go beyond the measures dictated by the immediate necessities. The medical company also provides Echelon I care to those units without organic medical elements within its area of responsibility (AOR).

Echelon III

The ANA RMHs located at Kandahar, Gardez, Herat and Mazar-e-Sharif are staffed and equipped to provide Echelon III medical care. This echelon of care includes medical activities such as: resuscitation, surgery, and postoperative treatment. Patients are stabilized for continued evacuation or returned to duty (RTD). Those patients not expected to RTD within the theater evacuation policy are stabilized and evacuated to the NMH in Kabul, or other Afghan National Government Health Care System Specialty Centers as appropriate.

Echelon IV

This echelon provides a definitive and rehabilitative treatment capability for patients. This echelon of care is provided by the NMH and Annex Hospital in Kabul or other Afghan National Government Health Care System Specialty Centers, like the National Public Health or Ministry of Higher Education Hospitals.

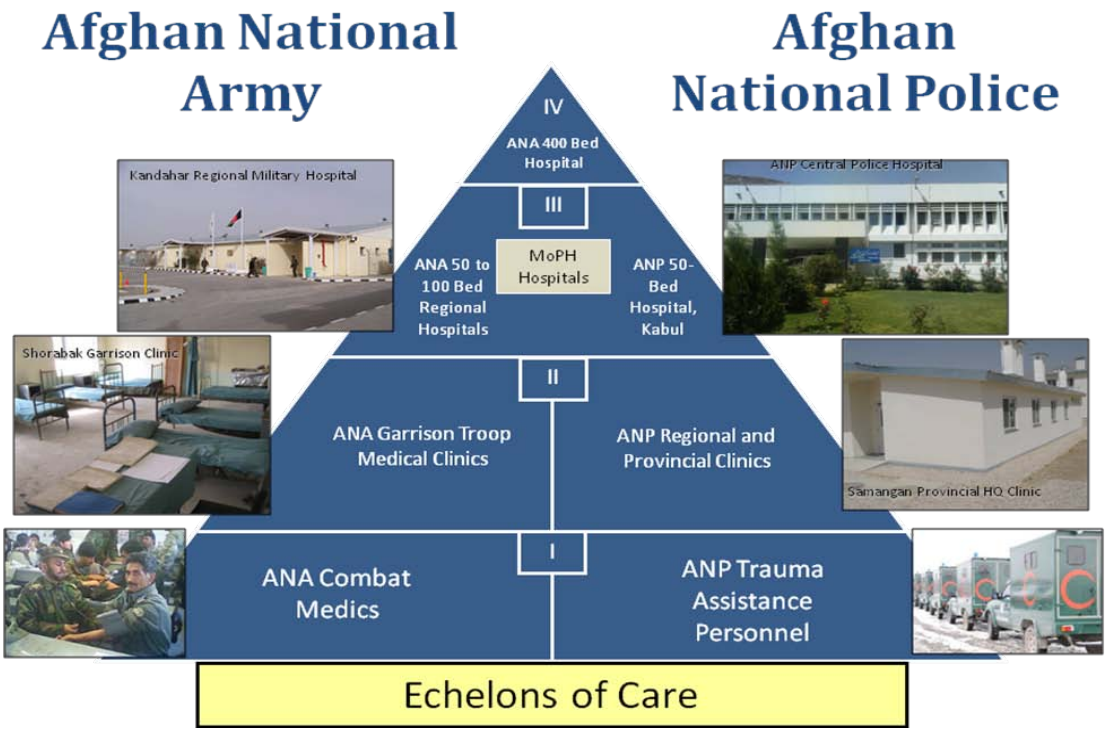

Figure 1.Depicts the ANA and ANP Healthcare Systems Echelons of Care

ANA Corps and Above Healthcare Structure

The Office of the Surgeon General provides advice to the Minister of Defense and oversight of the operations and maintenance of the Armed Forces Academy of Medical Sciences, the Dawood NMH and the four RMHs. The RMHs and NMH are prepared to provide all echelons of health care.

The Directors of the RMHs report to, and receive guidance from the OTSG. Each RMH has a dedicated Medical Depot near the hospital.

ANA Corps and Below Combat Health Support Structure

The combat forces of the ANA are organized into six Corps. Each Corps has between two and four brigades and each brigade has up to six Kandaks. Corps and below healthcare is limited to Echelons of Care I and II.

At the Corps level, there is a Corps Surgeon Office. The Corps Surgeon is responsible for the overall health and welfare of the members of the Corps, and to a degree, the eligible dependants.

The Corps Surgeons Office plans, coordinates and supervises Corps-level medical operations and logistics, provides oversight on medical training within the Corps, and oversees Preventative Medicine activities.

Each brigade has a Brigade Surgeon Office, which has similar responsibilities as the Corps Surgeon office, but focuses on the brigade. Each Brigade also has a Troop Medical Clinic (TMC), which provides Echelon II care to troops and eligible family members. The TMC is also responsible for preventative medicine activities within the brigade.

Each brigade has up to four Infantry Kandaks, and one Combat Support (CS) kandak. These kandaks contain one Treatment Platoon each.

The Treatment platoon provides Echelon I care and patient evacuation for the kandak. The unit has no official patient holding capacity.

Each brigade also contains one Combat Service Support kandak and the medical personnel in this unit supplement the Echelon I care and ground evacuation for the brigade's operations.

The medical company also operates a Class VIII warehouse for resupply to the units within the brigade and operates a field hospital that provides additional Echelon I patient stabilization and patient holding for patients awaiting evacuation to higher Echelons of care.

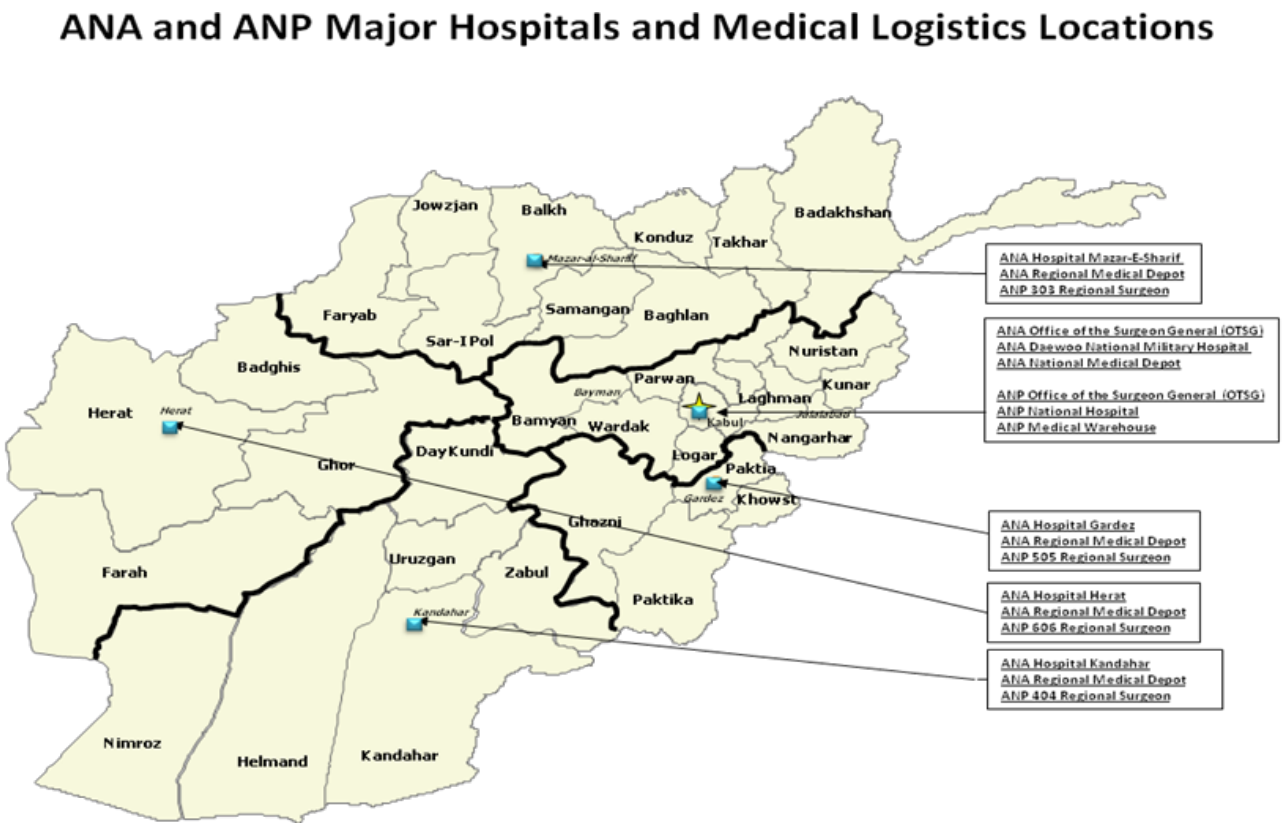

Figure 2. Depicts Major ANA and Police Hospitals and Medical Logistics Locations

ANA Medical Logistics Structure Overview

The ANA medical logistics system consists of the following fixed facilities:

- ANA National Medical Depot – Kabul (201st Corps)
- Regional Medical Depot - Mazar-E-Sharif (209th Corps)
- Regional Medical Depot – Herat (207th Corps)
- Regional Medical Depot – Gardez (203rd Corps)
- Regional Medical Depot – Kandahar (205th Corps)
- LOGCOM CL VIII Depot (pending relationship change with MEDCOM) houses some ANA requirements in the form of Trauma and Ambulance Kits.

Ministry Decrees Appropriate to Logistics

MoD Decree 4.0 (Logistics Policy and Support Procedures)
This decree is the most important logistics decree for the ANA. It establishes common procedures, formats, and forms for the communication of logistics information between supported activities and the supply & materiel management functions of the MoD. Some of the topics that are covered in great detail are roles and responsibilities of MoD logistics offices, warehouse operations, the MoD 14 resupply request process, the MoD 9 supply distribution process. Decree 4.0 also describes how to fill out most of the important logistics forms.

MoD Decree 4.2 (Material Accountability)
This decree outlines basic policies and procedures that apply in accounting for military materiel, including: the rationale and system for materiel accounting; implementation procedures accounting for different types of materiel; and establishment of accounting procedures used when materiel is lost, damaged, or destroyed other than through standard wear and tear. Critical materiel resources must be meticulously accounted for and tracked by appropriate accountable officials, and they are fully expected to adhere to the rigid rules and standards established by the MoD

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Appendix F. Summary of the DoDIG Quick-Look of the ANA National Military Hospital

Background

In response to concerns identified in an inspection report issued by a joint team of the Inspectors General of the Ministry of Defense and Combined Security Transition Command – Afghanistan (CSTC-A), the DoD Inspector General tasked his organizational components based in Afghanistan to assess the current status of healthcare at the Afghan National Army's National Military Hospital (NMH) in Kabul.

Discussion

Five days later, an OIG team composed of six members of the DoDIG Special Plans and Operations and Audit office, along with MG Gary Patton, DCOM-Army; BG David Neasmith, ACG-Army Development; COL John Ferrari, DCOM-Programs; the incoming and outgoing CSTC-A Command Surgeons; and the CSTC-A IG visited the NMH on Feb 21, 2011. The team was met at the hospital by LTG Akram (Vice Chief of the General Staff), the ANA Surgeon General, the Hospital Commander and other hospital personnel who accompanied the visit.

The team found notable progress had been made in certain areas since the report provided the DoD IG, especially with respect to general sanitation of medical facilities and medical supplies for patient care. In addition, the senior management of the Medical Command and the NMH had been replaced. But, other problems endemic to the Afghan military and public health care systems still persisted. These problems included:

a. The NMH hospital was understaffed, including; physicians, nurses, administrators and other staff, and their quality and attendance were problematic.
b. Though the MoD had signed the order directing the transfer of MoD Medical Logistics currently under the OTSG/MEDCOM to LOGCOM to gain better MoD management control, this had not occurred.
c. There was evidence that the medical logistics system delivery of medical supplies to the hospital's pharmacy and between the pharmacy and the patients was dysfunctional.
d. Orthopedic operating tables, valued over $400K were found in original packing crates, and believed to be beyond the capability of the ANSF medical staff.

Moreover, the goals with respect to ANSF health care standards to be achieved had not been defined. Therefore, it had not been possible for the Coalition to build the most effective medical mentoring model, one that is closely linked to these standards and the necessary supporting health care policy. The team concluded that the lack of ANSF medical standards and policy was a significant limitation with respect to NTM-A command efforts to develop a sustainable ANSF medical system. By having established medical standards and implementing policy, on the other hand, the appropriate required ANSF resources could be determined and allocated in order to achieve this end-state.

NTM-A/MTAG appeared to be moving aggressively to make the necessary adjustments that will enable a sustainable health care system to be established so that the ANSF can make a successful transition to taking the lead in providing medical care to their security forces by taking the following actions:

a. The CSTC-A IG continued oversight to further improve NMH performance.
b. Working with the NGO CURE International and the ANSF to define, promulgate and implement Standards of Care for the ANSF.
c. CSTC-A stood up an Operational Planning Team with the ANSF on Mar 1, 2011 to establish performance milestones and decision points.
d. Pursuing the appropriate numbers, skills, and seniority of Coalition health care development mentors, as well as requesting appropriate pre-deployment training for medical mentors.
e. Engaged with ISAF in developing the Coalition's policy delineating the "Division of Responsibility" between the ANA and ANP to provide effective healthcare for the ANSF.

Recommendations

The OIG team with the concurrence of NTM-A/CSTC-A made a few key recommendations, as follows:

1. OSD/Joint Staff should provide support to NTM-A/CSTC-A medical mentoring efforts by sourcing an adequate number of medical personnel with the "right' skill sets needed to accomplish the mission.
2. OSD/Joint Staff should support the Command's effort by supplementing the basic Program of Instruction (POI) provided military personnel before deployment to Afghanistan with medical mentor training.
3. DoD IG should conduct a follow-on assessment mission focused on the CSTC-A/ANA Action Plan for ANSF Healthcare to the ANSF and its implementation.
4. DoD IG should conduct an Audit concentrating on the medical logistics supply chain.

Recommendations 1 and 2 were addressed in the reporting and recommendations contained in the Medical Logistics report preceding these appendices. The assessment contained in recommendations 3 is anticipated in the January 2012 timeframe and is currently under development within DoDIG.

The audit contained in Recommendation 4 will be announced in June 2011. The audit objective is to determine the effectiveness of the pharmaceutical distribution within the Afghanistan National Security Forces health care system. Specifically, the audit will evaluate the procurement, delivery, and inventory control processes for pharmaceuticals at Afghanistan National Security Forces medical facilities and depots. The audit will be performed at multiple sites throughout Afghanistan. The auditors will interview and obtain information from the NATO Training Mission-Afghanistan/Combined Security Transition Command-Afghanistan and other subordinate directorates that handle the logistics procurement and management of pharmaceuticals.

Appendix G. Management Comments

NATO Training Mission – Afghanistan / Combined Security Transition Command – Afghanistan

HEADQUARTERS
NATO TRAINING MISSION – AFGHANISTAN
COMBINED SECURITY TRANSITION COMMAND – AFGHANISTAN
KABUL, AFGHANISTAN
APO, AE 09356

7 May 2011

MEMORANDUM THRU

United States Forces-Afghanistan (CJIG), APO AE 09356
United States Central Command (CCIG), MacDill AFB, FL 33621

FOR Inspector General Department of Defense, 400 Army-Navy Drive, Arlington, VA 22202

SUBJECT: NTM-A/CSTC-A Response to Observations and Recommendations in DoDIG Report D2011-D00SPO-0092.000, "Assessment of U.S. Department of Defense Efforts to Develop an Effective Medical Logistics System within the Afghan National Security Forces."

1. Reference: DoDIG Report D2011-D00SPO-0092.000, subject as above.

2. The purpose of this memorandum is to provide the NTM-A/CSTC-A response to observations and recommendations contained in the report referenced.

3. The point of contact for this Command is COL Mark F. Fassl, Command Inspector General at DSN (318) 237-1076 or mark.f.fassl@afghan.swa.army.mil.

GARY S. PATTON
MG, U.S. Army
Deputy Commander - Army

ENCL:
NTM-A/CSTC-A Response to DoDIG DRAFT REPORT D2011-D00SPO-0092.000, dated 31 March 2011
MoD 14 Tracker – Recommendation 3b
Solar Year 1390 Medication Requirements – Recommendation 5a
Afghan National Army Health Care System Pharmaceutical and Therapeutics Committee By-Laws, Established 3 August 2006 – Recommendation 5c
Destruction of Expired Drugs – Recommendation 6d
1390 Approved MEDCOM Bio Med Tashkil Positions – Recommendation 8b

NTM-A/CSTC-A Response to DoDIG DRAFT REPORT D2011-D00SPO-0092.000

NTM-A/CSTC-A Response to the Draft Report (D2011-D00SPO-0092.000)

Observation 1 (Report Page 5)

Class VIII FMS and NTM-A/CSTC-A purchasing processes perpetuate dependence on a U.S. supply chain.

DODIG Recommendation 1: NTM-A/CSTC-A partner with LOGCOM and OTSG to develop and implement a plan to transition, where feasible, Class VIII requirements generation and acquisition processes to the MoD.

> **NTM-A/CSTC-A Response:** Concur. NTM-A/CSTC-A is taking action to transition requirements generation and acquisition of Class VIII material/supplies to the MoD. During this transition period, NTM-A/CSTC-A will work to put in place a capability to procure Class VIII material through local acquisition processes or through Foreign Military Sales.

Observation 2 (Report Page 7)

Incorporation of Class VIII supply management under MoD/LOGCOM has not been fully implemented.

DODIG Recommendation 2a: NTM-A/CSTC-A advise and assist LOGCOM and OTSG to define where LOGCOM and OTSG Class VIII responsibilities begin and end.

> **NTM-A/CSTC-A Response:** Concur. The Minister of Defense signed order #4448 transferring the supply depots from OTSG to Logistics Command of AT&L in Solar Year 1389 (2010). OTSG, now Medical Command (MEDCOM), has been and continues to be advised on where their responsibility ends and Logistics Command (LOGCOM) responsibilities begin. The MEDCOM Commander publicly acknowledged the move, precipitated by a GS mentor mediated call from the Vice Chief of the General Staff to reinforce the fact that Class VIII does not belong to MEDCOM. On 25 April 2011, NTM-A/CSTC-A facilitated a meeting between the Chief, LOGCOM, and the Deputy MEDCOM Commander for Administration and Operations. This first ever meeting clearly laid out the responsibilities of the two organizations with full concurrence.

DODIG Recommendation 2b: NTM-A/CSTC-A advise and assist LOGCOM and OTSG to develop a formal implementation plan for LOGCOM assumption of Class VIII responsibility.

> **NTM-A/CSTC-A Response:** Concur. The implementation and assumption of Class VIII by LOGCOM is complete. The medical depots in the regions know they now work for the FSD commander and NMH is getting its support directly from the Class VIII warehouse per Decree 4.0. We continue to train and mentor the process at every level.

DODIG Recommendations 2c: NTM-A/CSTC-A advise and assist LOGCOM and OTSG to formally communicate changes in Class VIII support to all levels of the supply chain.

> **NTM-A/CSTC-A Response:** Concur. The change has been officially communicated on numerous occasions. See response 2a. NTM-A/CSTC-A will continue to monitor the situation to determine if a formal memorandum from the MEDCOM commander is necessary.

DODIG Recommendation 2d: NTM-A/CSTC-A advise and assist LOGCOM and OTSG to provide follow-up oversight to ensure compliance.

> **NTM-A/CSTC-A Response:** Concur. Class VIII has been added to the Logistics Validation Team site surveys. The Logistics Training Advisory Group (LTAG) and Medical Training Advisory Groups (MTAG) conduct continuous Battle Field Circulations and provide daily follow-up as part of their mentoring duties.

Observation 3 (Report Page 9)

Class VIII FMS acquisition was not properly planned and coordinated with MoD/ANA stakeholders.

DODIG Recommendation 3a: NTM-A/CSTC-A, in coordination with MoD and ANA, build a FMS requirements generation process, starting with the lowest levels of RMHs, concluding with RMH Commander and appropriate OTSG staff approval.

> **NTM-A/CSTC-A Response:** Concur. The next FMS case will be based on the ANA Solar Year (SY) 1390 requirements. The SY1390 requirements were built using input from RMH, Corps and below units, SOF, the ANA, Afghan Air Force, and other units. The ANA will use their 351 million Afghani SY1390 budget to buy the requirements they can and request NTM-A/CSTC-A to purchase the remaining requirements. The SY1390 requirements were sent to the RMH so they could re-validate and have the opportunity to provide feedback before any purchases are made. NTM-A/CSTC-A is directing mandatory logistics training for all mentors so they understand the process.

DODIG Recommendation 3b: NTM-A/CSTC-A, in coordination with MoD and ANA, create a feed-back loop to inform RMH and depot staff which requested items will be filled, which will not, and the reason(s) why.

> **NTM-A/CSTC-A Response:** Concur. The Logistics Support Operations Center (LSOC) in coordination with NTM-A/CSTC-A is developing an automated system to pass the status of parts on-order through the chain of command for the due-in date. Additionally, for the feed-back loop, LSOC created a MoD Form 14 Tracker that units can reference to make sure their MoD Form 14s were received and submitted to the Class VIII warehouse. LSOC also created a customer service line for customers to check on status of requisitions. The ANA and mentors work together to utilize the system to check on the status of their MoD Form 14s.

The system exists in the Decrees; the mentors encourage their mentees to use the proper forms according to their Decrees. Customers in the ANA use the MoD Form 14 process to request items as per the ANA Decrees. If less than the full amount on the MoD Form 14 is available, then the logistics nodes (i.e. FSDs, Corps G4s, FSG, and LSOC) use a MoD Form 2 (Stock Accounting Record) to record the issues and receipts. This is a basis to audit for materiel accountability, distribution for arriving materiel due-in, and a means to periodically validate due-in demands with each supporting depot. In conjunction with the MoD Form 2, logistics nodes use a MoD Form 1298 (Due-Out Log) to establish a record of the materiel/stocks owed to a supported unit until all requests are completed/ completely filled with stock as requested. The logistics nodes retain the MoD Form 1298 with the MoD Form 2 that it is associated with. Items not available through the supply system, if deemed required, are acquired through NTM-A/CSTC-A FMS for Foreign Military Sales and/or through NTM-A/CSTC-A Local Acquisition for local acquisition items as well as through the ANA Procurement Agency. Attached is an example of the tracking document that shows how they verify/track the MoD 14's.

Observation 4 (Report Page 13)

A defined Authorized Stockage List (ASL) has not been established for the ANA Class VIII supply chain.

DODIG Recommendation 4a: NTM-A/CSTC-A, in coordination with OTSG, develop ASLs for each RMH department and pharmacy.

NTM-A/CSTC-A Response: Concur. The RMHs are in the process of collecting usage data so they can begin to establish their local inventory levels at the RMH. Each RMH has a contractor who is tasked to collect that information and have it available by June 2011.

DODIG Recommendation 4b: NTM-A/CSTC-A, in coordination with LOGCOM, develops ASLs and requisition objectives for medical FSDs.

NTM-A/CSTC-A Response: Concur. All RMHs and the NMH submitted their SY1390 requirements. LOGCOM uses the SY1390 requirements as the starting point for creating the Class VIII ASL. Upon establishment of the ASLs, Logistics Support Operations Center, and the FSDs/Class VIII warehouses set appropriate requisition objectives in order to help maintain the correct amount of stock on hand at all times at the FSDs and CLVIII warehouses. Mentors help their mentees to select the appropriate requisition objectives based on historical data. The FSDs and Class VIII warehouses use the MoD Form 14 to reorder CLVIII supplies once stock reaches the requisition objective point

DODIG Recommendation 4c : NTM-A/CSTC-A establish an alert system to indicate, based on feedback from medical mentors down the supply chain, when MoD Form 14 orders are not filled, and provide this feedback to MoD for reconciliation purposes.

NTM-A/CSTC-A Response: Concur. Please reference response 3b.

Observation 5 (Report Page 15)

The Afghan National Army did not have a standardized list of medications and consumable supplies.

DODIG Recommendation 5a: NTM-A/CSTC-A, in coordination with the Office of the Surgeon General (OTSG), establishes a standardized list of needed pharmaceuticals (drug formulary) and related medical supplies. The list of medications should be based upon the current National Licensed Drug list promulgated by the Ministry of Public Health.

> **NTM-A/CSTC-A Response:** Concur. A formulary was established for SY1389. OTSG has established a standardized SY1390 medication formulary and respective quantity requirements per the attached document. This list is based upon the National list promulgated by MoPH.

DODIG Recommendation 5b: NTM-A/CSTC-A, in coordination with the OTSG, establish authorized stock lists specific to medications that are based on the level of care provided and health care provider input.

> **NTM-A/CSTC-A Response:** Concur. ANA is underway with implementing an electronic inventory management system, CORE IMS. This is a precursor step supporting the establishment of inventory levels for individual work centers and hospital departments. Pharmacy mentors established ASLs for pharmaceuticals. Also see response to 4a.

DODIG Recommendation 5c: NTM-A/CSTC-A, in coordination with the OTSG, to incorporate a medication requirements generation process to obtain suggestions for medication additions and deletions to the standard list of medications.

> **NTM-A/CSTC-A Response:** Concur. MEDCOM currently coordinates an annual and ad hoc Pharmacy Therapeutics Committee for generating annual ANA medication formulary updates and respective quantity requirements. This committee has existed since 2006. Original policy attached.

DODIG Recommendation 5d: NTM-A/CSTC-A, in coordination with the OTSG, develop and disseminate product catalogs through the ANA supply chain.

> **NTM-A/CSTC-A Response:** Concur. The Core Inventory Management System (CORE IMS), which is currently being fielded, has catalog information. 1st FSD, 2nd FSD, 3rd FSD and 4th FSD have the ability to utilize CORE IMS. Every time a new item is entered into CORE IMS a unique number is created to identify that item through the material control register. Customers can log into CORE IMS and print the catalog information. If for some reason the RMH or TMC's can't access CORE IMS they can get hard copy catalog information from the FSD or National Supply Depot (NSD).

Observation 6 (Report Page 17)

ANSF leaders reported a lack of confidence in the quality of pharmaceuticals supplied from MoD purchased sources.

DODIG Recommendation 6a: NTM-A/CSTC-A advise and assist the Ministry of Defense in the issuance of a mandate that limits the selection of sources for pharmaceuticals and medical supplies to WHO, UNICEF, FDA or other approved sources for central purchases through procurements to assure quality.

> **NTM-A/CSTC-A Response:** Concur. NTM-A/CSTC-A continues to advise and assist the Ministry of Defense on this issue, and this was a topic of discussion during our recent Program Management Review. The desired outcome of this mandate would be to limit the selection of sources for pharmaceuticals and medical supplies to vendors that are USAID approved sources. USAID, through these vendors already provide pharmaceuticals to the Ministry of Public Health in Afghanistan.

DODIG Recommendation 6b: NTM-A/CSTC-A advise and assist the Assistant Minister of Acquisition, Technology and Logistics in development and promulgation of policy that ensure contracting procedures dictate "quality trumps cost" and not "contract goes to the lowest bidder" when purchasing requirements of medications and medical supplies.

> **NTM-A/CSTC-A Response:** Concur. CSTC-A met with the Assistant Minister of Acquisition Technology and Logistics to discuss how our Acquisition Teams could work more closely together to further develop the ANA Acquisition and Procurement Strategy. The Assistant Minister designated BG Wakil (Head of the ANA Acquisition Agency) as our point of contact for CSTC-A to work on the further development of procurement strategy and policy. We continue to advise BG Wakil on both procurement policy and purchasing requirements for medications and medical supplies. Our point of view is that GIRoA Procurement Law 2008, Articles 18, 19 and 23 all address this issue and allow exceptions to the low bid contract direction for procurement.

DODIG Recommendation 6c: NTM-A/CSTC-A revisit the feasibility of purchasing vaccines through WHO/UNICEF approved sources as a more cost-effective alternative without compromising product quality.

> **NTM-A/CSTC-A Response:** Concur. NTM-A/CSTC-A concurs with this recommendation and is taking action to determine the feasibility of US pseudo-FMS to purchase vaccines through non-FDA approved sources to possibly include USAID, WHO and UNICEF approved sources.

DODIG Recommendation 6d: NTM-A/CSTC-A, in coordination with the OTSG, provide timely instructions to report and remove counterfeit and expired medications from the logistics chain.

NTM-A/CSTC-A Response: Concur. There is language in the update to Decree 4.0 that gives units instructions on how to turn in and destroy expired items. If there are items identified as counterfeit the Class VIII NSD and FSD will inform their customers and will issue instructions on what to do IAW with Decrees. We continue to train and mentor the process at every level.

Observation 7 (Report Page 21)

The Military Entrance Processing Station (MEPS) lacked vaccines for ANA recruits.

DODIG Recommendation 7: NTM-A/CSTC-A mentor the OTSG to identify vaccine requirements (projected needs) and ancillary requirements (turberculin syringes, alcohol pads) and ensure required supplies are on hand or shipped in advance of need.

NTM-A/CSTC-A Response: Concur. The MTAG preventive medicine section is in the process of mapping the ANA vaccine process and identifying the points of failure. CL VIII is working on establishing a vaccine Authorized Stockage Listing (ASL) based on the SY1390 requirements. The ASL is used to help maintain the proper CLVIII items on hand at the lowest levels (NMH/ RMH/ regional CLVIII warehouses).

There is an approved SY1390 vaccine distribution plan that covers all ANA sites. MEDCOM Chief of Preventive Medicine (PM) receives monthly updates from all the Corps and training sites. MTAG PM is going out to the sites verifying that they have the vaccine that they say they have and then tracing where the breakdown is occurring. There is some confusion with the MoD 14 process in the Regions. Some of them are getting what they order while others are not.

Preventive Medicine and Logistics mentors help their mentees to select the appropriate requisition objectives based on historical data and work together to educate the field on Decrees 4.0 and 4.2.

Observation 8 (Report Page 23)

ANA medical equipment was not being maintained.

DODIG Recommendation 8a: NTM-A/CSTC-A partner with appropriate ANA directorates to fill FSD Biomedical Equipment Maintenance vacancies.

NTM-A/CSTC-A Response: Concur. The real problem is the lack of an available pool of trained BMET workers to fill these positions. The most sustainable course of action is the BMET training course, with a bridging contract to cover the gap between the start of the program April 2011 and when these students will be able to perform their craft independently. A pending Medical Maintenance contract(s) will take care of all ANA MEDCOM facilities and will have 2 additional option years. At present we have interim repairs/maintenance ready to execute at: Darulaman, Gardez, Herat, Jalalabad and Kabul.

IJC and NTM-A/CSTC-A are working to define equipment maintenance needs for Corps and below medical assets. This estimate should be complete by July 2011.

DODIG Recommendation 8b: NTM-A/CSTC-A mentor the OTSG/G1 to adjust the Tashkil in order to place Biomedical Equipment Technicians at all RMHs.

NTM-A/CSTC-A Response: Concur. The 1390 Tashkil MEDCOM numbers are good overall but need to be realigned for some locations/positions. Current MEDCOM BMET manning has remained unchanged since 1389. Regional BMET positions need to be returned to the RMCs. NTM-A/CSTC-A is working this issue for the 1391 Tashkil.

DODIG Recommendation 8c: NTM-A/CSTC-A mentor the OTSG to develop a deliberate medical maintenance and medical equipment visibility system to supplement the current property book.

NTM-A/CSTC-A Response: Concur. The Medical Equipment Management Office policy is in the draft stages. This will augment the base property book and provide a more comprehensive plan to account for medical equipment located within the facility. NMH currently has a MEMATS (Medical Equipment Management and Tracking System) program. This program is in the final stages of development by RANA technologies to track all medical assets within the facility. This will provide details of life cycle management in addition to a scheduled and unscheduled maintenance program. The sustainability of this program is being assessed and an alternate off-the-shelf maintenance/accountability program is being considered at this time.

Observation 9 (Report Page 25)

Requisitions submitted to FSDs and the national Depot were not acknowleged.

DODIG Recommendation 9a: NTM-A/CSTC-A, in partnership with LOGCOM, create a feedback mechanism acknowledging MoD Form 14 receipt and acceptance.

NTM-A/CSTC-A Response: Concur. Logistics Support Operations Center (LSOC) created a MoD Form 14 Tracker for units to reference to make sure their MoD Form 14s are received and submitted to the Class VIII warehouse. Additionally, LSOC created a customer service phone line for customers to check on status of requisitions. At each of the established FSDs, as well, there is a customer service representative to check on status of requisitions. The ANA and mentors work together to utilize the system to check on the status of their MoD Form 14s. Additionally, mentor / ANA training classes emphasize proper procedures for filling out the MoD Form 14.

DODIG Recommendation 9b: NTM-A/CSTC-A, in partnership with LOGCOM, create a process with customers to reconcile materiel requests sent to and received by the National Medical and Forward Supply depots to avoid distribution of duplicate items.

NTM-A/CSTC-A Response: Concur. In the past, the National Supply Depot (NSD) pushed material to the FSDs causing duplicate distribution of items; now, the Class VIII NSD does not plan to push any materiel to the FSDs. Customers request items solely via the MoD Form 14 Process detailed in the ANA Decrees.

Observation 10 (Report Page 27)

Unfilled Class VIII requirements were not systematically captured.

DODIG Recommendation 10a: NTM-A/CSTC-A mentor OTSG to create an RMH-level control mechanism to ensure unfilled demands are recorded and tracked at that level.

NTM-A/CSTC-A Response: Concur. MoD Form 2, as stated in answer to question 3b and 4c, is used to record the remaining balance on a MoD Form 14 that is not currently available through the supply system. MoD Form 2 provides a record of requests/ demands and turn-ins. This is a basis to audit for materiel accountability, distribution for arriving materiel due-in, and a means to periodically validate due-in demands with each supporting depot. Mentors assist mentees at the RMH-level to properly use the MoD Form 2.

DODIG Recommendation 10b : NTM-A/CSTC-A partner with MoD LOGCOM to ensure MoD Decree 4.0 and related guidance pertaining to tracking supply requests are followed by the Medical FSDs and the National Depot now under MoD LOGCOM.

NTM-A/CSTC-A Response: Concur. Mentors at each FSD help the medical ANA soldiers at the Class VIII warehouse use MoD Decree 4.0 and related guidance pertaining to tracking supply requests through the following: training sessions, Mobile Training Teams, the Validation Team, and everyday oversight of mentee actions. Additionally, the FSD mentors ensure that the mentees are kept informed of changes to MoD Decrees and receive copies in Dari of all guidance.

Observation 11 (Report Page 33)

Controls over the receipt, storage, accountability, and distribution of pharmaceuticals and other Class VIII supplies were insufficient to prevent theft, misappropriation, unauthorized use, or improper distribution.

DODIG Recommendation 11a: NTM-A/CSTC-A mentor MoD and ANA, MoI and ANP officials to establish and enforce standard controls over the receipt, storage, accountability, and distribution of pharmaceuticals and other Class VIII supplies in order to prevent theft, misappropriation, unauthorized use, or improper distribution. Ensure this includes regular independent MoD and MoI oversight inspections.

NTM-A/CSTC-A Response: Concur. Accountability was one of the primary reasons for the move of Class VIII from MEDCOM to LOGCOM. Unlike MEDCOM, which required little to no paperwork to issue out material, the Class VIII National Supply Depot requires a MoD Form 14 (for standard requisitions) or Push Letter (for initial

fielding). The FSD also requires a MoD Form 14 to release materiel. When supplies are received a proper inventory is conducted. This change improved accountability while reducing theft, misappropriation, unauthorized use and improper distribution. The MoD and MoI IG also inspect regularly.

DODIG Recommendation 11b: NTM-A/CSTC-A and IJC medical mentors regularly inspect the status of Class VIII oversight, and report results to the Commander, NTM-A/CSTC-A and Commander, IJC, as well as the ANA OTSG and ANP OTSG.

NTM-A/CSTC-A Response: Concur. LTAG mentors provide oversight as part of their daily mentoring at all levels. The Logistics Validation Team does an assessment quarterly. The MoD and MOI IG also inspect regularly.

ISAF Response: Concur.

Observation 12 (Report Page 37)

Ministry of Defense Decrees 4.0 and 4.2 were not effectively implemented or enforced.

DODIG Recommendation 12: NTM-A/CSTC-A mentor MoD and ANA officials to define and promulgate standard operating procedures and other medical materiel control mechanisms to ensure compliance with existing inventory management and accountability policies specified by Decrees 4.0 and 4.2.

NTM-A/CSTC-A Response: Concur. Mentors at each FSD help the MoD and ANA officials use MoD Decree 4.0 and 4.2 through training sessions, the Logistics Mobile Training Team, and everyday oversight of mentee actions. Additionally, the mentors ensure that the mentees stay informed of changes to MoD Decrees and receive copies in Dari of all guidance. Standard operating procedures are implemented, as necessary, at each level. While training was not achieved at the end user level, that is being corrected within each MTF as well as mandated for all mentors in "pre-employment" training.

Observation 13 (Report Page 39)

NTM-A/CSTC-A did not have clear data visibility and accountability for medical logistics contracts and purchase costs.

DODIG Recommendation 13a: NTM-A/CSTC-A develop a financial management process that captures ANSF medical logistics procurement costs and contracts.

NTM-A/CSTC-A Response: Concur. A holistic capture of information is needed to efficiently and effectively procure/contract pharmaceuticals, vaccines and medical supplies. CSCT-A is pursuing procurements from several means to include foreign military financing (FMF), foreign military sales (FMS), pseudo-FMS, direct funding, and local procurements.

DODIG Recommendation 13b: NTMA/CSTC-A use Commander Logistics Procurement Support Board (Ref Joint Publication 4-10, "Operational Contract Support," October 17, 2008) to ensure that contracting and other related logistics efforts are properly coordinated across the Combined Joint Operations Area-Afghanistan.

NTM-A/CSTC-A Response: Concur. USFOR-A /CCC facilitates the Interagency Combined Joint Logistics Procurement Support Board (I+6). NTM-A/CSTC-A will ask the I +6 Logistics Procurement Support Board to have a Medical Logistics review.

Observation 14 (Report Page 43)

Excess Class VIII Medical Logistics Stocks and Equipment are prevalent throughout the system with no evident plan for periodic supply redistribution or disposition.

DODIG Recommendation 14a: NTM-A/CSTC-A mentor OTSG to build a plan that captures RMH-level excess supplies and redistributes to other supporting FSDs.

NTM-A/CSTC-A Response: Concur. Plans have already been established to move excess supplies from the regional depots to the Class VIII warehouse. The ANA has agreed to the plan, but getting them to follow through will be difficult because of cultural resistance to give anything up. NTM-A/CSTC-A is working with MoD to work through these cultural barriers with a retrograde of bed pans, an innocuous item with a low likelihood of theft or sensitivity to accusations of corruption, in Herat. This will assist with mapping the actual process as well as identifying the real points of friction and resistance to follow through.

DODIG Recommendation 14b: NTM-A/CSTC-A mentor OTSG to implement the Core Inventory Management System, including the centralized data base that identifies medical supplies in the ANA HCS depot system.

NTM-A/CSTC-A Response: Concur. 1st FSD, 2nd FSD, 3rd FSD and 4th FSD utilize Core Inventory Management System (CORE-IMS) to varying degrees. Additionally, by the end of June 2011, logistics managers at the NMH will use CORE-IMS. The mentors at each logistics node provide oversight, training, and direction to the mentees to encourage use of the system.

DODIG Recommendation 14c: NTM-A/CSTC-A mentor MoD to clarify and reinforce policy contained in Decree 4.0 regarding the disposal of excess and expired material.

NTM-A/CSTC-A Response: Concur. There is new language in Decree 4.0 outlining the steps to be followed for expired items. Plans have already been established to move excess supplies from the regional depots to the Class VIII warehouse. The ANA has agreed to the plan but getting them to follow through will be very difficult because of cultural resistance to give anything up.

Observation 15 (Report Page 47)

Lack of a standard ANA Class VIII warehousing plan.

DODIG Recommendation 15a: NTM-A/CSTC-A mentor OTSG to build a standard NMH and RMH warehousing plan.

> **NTM-A/CSTC-A Response:** Concur. Either a draft or finalized SOP exists at each storage location at this time. Although each CLVIII storage facility is physically different, the mentors will work with the NMH and RMHs logistics leaders to standardize organization in similar matters (i.e.- by pharmaceuticals, consumables, and bulk items) for storage of Class VIII and to ensure the ANA at each location can locate stock easier and conduct better inventory management.

DODIG Recommendation 15b: NTM-A/CSTC-A partner with LOGCOM to build a FSD and national Depot Class VIII warehousing plan.

> **NTM-A/CSTC-A Response:** Concur. As stated in Response 15a, either a draft or finalized SOP exists at each storage location at this time. Although each warehouse facility is physically different, mentors will work with the CLVIII warehouse managers to standardize organization in similar matters (i.e. by pharmaceuticals, consumables, and bulk items) for storage of the Class VIII ASL when it is approved. This will allow ensure the ANA at each location can locate stock easier and conduct better inventory management.

DODIG Recommendation 15c: NTM-A/CSTC-A mentor LOGCOM and OTSG to periodically inspect implementation of these plans.

> **NTM-A/CSTC-A Response:** Concur. NTM-A/CSTC-A will periodically inspect implementation of these plans, as well as mentor the MoD to conduct inspections.

Observation 16 (Report Page 55)

Lack of defined standards of medical care for ANA and ANP health care systems.

DODIG Recommendation 16: ISAF, in coordination with MoD, MoI, and the MoPH, develop and execute plans that result in the development, codification, implementation, and enforcement of health care standards for the ANA and ANP HCS that are uniformly applied by Coalition medical mentors.

> **NTM-A/CSTC-A Response:** Partially concur. NTM-A/CSTC-A has the mission for institutional development within the ANA and the ANP medical systems. The development and execution of health care standards not only with the ANSF but also across the MoPH is already well under way. The CURE International standards are being implemented.

ISAF Response: The ANSF are currently working with mentors to implement Tier One hospital standards as defined by CURE International by contract. Additionally, ISAF is working with JHPIEGO to examine quality standards that they have developed for MoPH health facilities ranging from small out-patient facilities to district hospitals (community hospitals) and with HHS (CDC) on Joint Commission Essentials, a minimum but meaningful and effective validated international hospital standard for resource-constrained environments that MoPH is also reviewing. The ANSF will ultimately be responsible for the enforcement of these standards. Coalition medical mentors will utilize these standards as mentoring goals.

Observation 17 (Report Page 59)

Lack of operational planning for ANA medical leadership and institutional capacity development.

DODIG Recommendation 17a: ISAF, in coordination with MoD, MoI, and MoPH, develop and implement a joint, integrated plan for the development of a sustainable ANSF HCS system consistent with established medical standards.

ISAF Response: Concur that there must be an overall GIRoA strategy for ANSF HCS. ISAF, NTM-A/CSTC-A and IJC will jointly develop a single, integrated campaign plan for the development of a sustainable ANSF Health Care System and ensure it is properly nested in the overall GIRoA strategy.

DODIG Recommendation 17b: Under Secretary of Defense for Personnel and Readiness designate a reach-back partner institution for the Afghan Armed Forces Academy of Medical Sciences to include the "Research-to-Policy-to-Doctrine-to-Training-to-Execution" chain guidance.

NTM-A/CSTC-A Response: Concur. NTM-A/CSTC-A is working with USDP&R.

DODIG Recommendation 17c: NTM-A/CSTC-A mentor the MoD and ANA/OTSG, and the MoI and ANP/ OTSG to ensure ANA/ANP medical support requirements are included in MoD and MoI campaign plans and ANSF field planning and training.

NTM-A/CSTC-A Response: Concur. Working with both headquarters elements on developing robust and sustainable medical planning and operations capability. Both OTSG (ANP) and MEDCOM (ANA) have been asked to supply an ANA medical officer to work with NTM-A/CSTC-A and IJC in these arenas. We expect to have a fully joint effort by the end of May 2011. This team is actively reviewing requirements and fielding, as well as training.

DODIG Recommendation 17d: ISAF enable Coalition medical mentors to share "best practices" across ANSF medical facilities and with mentoring teams partnered with ANSF units, and also ensure U.S. mentors are able to effectively utilize JULLS "lessons learned" system.

NTM-A/CSTC-A Response: Concur. Please see response #19c; NTM-A/CSTC-A is already working with Center for Army Lessons Learned which has integrated capability with JULLS. In addition, IJC and NTM-A/CSTC-A have partnered two operations officers to perform site visits to each Region/Zone, work with all ANSF mentor teams, and assess the best way forward for both Above and Below Corps mentoring assets.

ISAF Response: Concur with recommendation.

Observation 18 (Report Page 63)

Lack of NTM-A/CSTC-A required medical mentor capability.

DODIG Recommendation 18a: ISAF, in coordination with MoD/ANA, assess Coalition medical mentor personnel needs based on specific ANA medical standards, once defined, and a corresponding ANA medical system development plan.

NTM-A/CSTC-A Response: Concur. Current mentor positions at Echelons Above Corps, MOD and MOI medical system are driven by demonstrated needs in regards to clinical skill set, administration, preventive medicine and support services (facilities, logistics and biomedical maintenance). Planning is guided by the 2014 transition goal, the development of the Tier 1 Afghan healthcare standards, and maturing concepts on how to effectively mentor. Our requirements for medical mentors will be provided to ISAF for review and approval.

ISAF Response: Concur. ISAF will review and approve these requirements

DODIG Recommendation 18b: NTM-A/CSTC-A review U.S. medical mentor RFF and JMD requests to ensure U.S. medical mentors will be appropriate for assignment to Afghan medical counterparts in terms of corresponding rank, previous medical training, and experience.

NTM-A/CSTC-A Response: Concur. The JMD, RFF, and CJSOR are the focus of continual review. The formal review process will conclude at the end of May after a Requirements Council which will finalize the planning for all of these positions through 2014 and an evaluation of any identified enduring missions. By June 2011 all position descriptions will be rewritten.

DODIG Recommendation 18c: NTM-A/CSTC-A, in coordination with MoD, identify the causes for the limited time spent per day mentoring Afghan medical counterparts in the ANA hospital system and implement appropriate adjustments to enhance mentoring effectiveness.

NTM-A/CSTC-A Response: Concur. One of the greatest challenges at NMH is staff absenteeism. NTM-A/CSTC-A continues to apply pressure at key leadership levels throughout the ANA medical system and MOD to address this chronic problem of accountability.

DODIG Recommendation 18d: ISAF request U.S. Army personnel only for assignment to key positions in which development of ANA HCS doctrine, tenet, or instruction is mentored. Recommend designating these key positions as "U.S. ARMY ONLY" - "NO SERVICE SUBSTITUTION ALLOWED."

NTM-A/CSTC-A Response: Partially concur. MTAG works closely with IJC, who are predominantly US Army personnel. This cross fertilization of knowledge and experience allows NTM-A/CSTC-A to implement US Army regulations and policy through Navy and Air Force officers who are more than capable in mentoring standards of healthcare and overarching leadership principles.

ISAF Response: ISAF does not concur with recommendation 18d. It is true that the present design is based on U.S. Army Medical Department however, it is not felt that this recommendation is necessary, particularly because there are current plans to have mentors from other Coalition countries and it will be advantageous to have them.

Observation 19 (Report Page 67)

Pre-deployment training and in-country orientation did not effectively prepare medical mentors.

DODIG Recommendation 19a: Under Secretary of Defense for Personnel and Readiness designate the Army Medical Department (AMEDD) Center and School or similar institution to be the Center of Excellence for MTAG pre-deployment training with an approved program of instruction that is tailored for the mission in Afghanistan.

DODIG Recommendation 19b: NTM-A/CSTC-A, in coordination with Commander, IJC, provide mandatory medical mentor orientation upon arrival in Afghanistan.

NTM-A/CSTC-A Response: Concur. At present, course content and the PoI have been modified for pre-deployment and in country training requirements based on feedback from participants in the Pilot Group and Group 2. Contacts have been made with plans to create slide presentations with voice over to provide to pre-deployment training sites so that content delivery is consistent for Medical Team Mentors in CONUS. Approximately 12 hours of content should be delivered in CONUS with an additional 6 – 8 hours to be completed once the team members arrive in country. Revisions of the presentations as well as the PoI in progress. After pre-deployment modules are complete, this content will be exported to pre-deployment training sites for utilization. In – country specific content, such as wiring diagram, ANA medical logistics, and introduction to the MTAG staff, will still be taught here when new team members arrive. The primary challenge with respect to completing these presentations is media services to assist with voice over of the slide presentations.

DODIG Recommendation 19c: NTM-A/CSTC-A ensure medical mentors receive continuous management guidance and support during their tours consistent with the Medical Handbook and newly emerging mentoring requirements.

NTM-A/CSTC-A Response: Concur. All mentors as of 1 March 2011 now report directly to Kabul on entering country for a three day orientation and guidance session, then engage in ten days hand over training with their predecessor before beginning their jobs. They are assigned a team leader who manages their daily duties. Teams have weekly telephone conferences with the Deputy Surgeon, and Team Leaders send weekly War reports up to the CMD Surgeon's office. The Command Surgeon has engaged in two battlefield circulations with quarterly BFC planned to each site. The Chief Nurse has regularly engaged in BFCs, runs weekly VTCs with nurse mentors across Afghanistan, and is heavily engaged with all nurses at all levels on a regular basis. Subject matter experts such as the senior Radiologist, senior Lab officer and sole Physical Therapist engage in BFC to perform site assessments, conduct training, and offer guidance and assistance to mentors as well as local providers. When feasible, they are accompanied by their chief mentees as a form of train the trainer. All mentors now also depart from Kabul. and engage with CALL and the MTAG staff to archive lessons learned and TTPs.

Observation 20 (Report Page 71)

ANA Medical personnel shortages.

DODIG Recommendation 20: ISAF mentor the MoD to focus on all available opportunities for providing the ANA with qualified Afghan medical personnel to fill ANA Tashkil positions to a level acceptable to the MoD.

NTM-A/CSTC-A Response: Concur. Must note that NMT-A/CSTC-A is responsible for mentoring. ISAF is not/cannot be responsible for mentoring (NATO organization). Significant partnered and focused effort to streamline the recruiting and accessions process is underway; the assessment period to measure effectiveness of these changes will provided initial data in May 2011.

ISAF Response: Concur with the recommendation.

Other Comments:

Page 51, first paragraph, second sentence: should read "The ISAF Joint Command (IJC) combat command mentors the ANP and ANA with their Coalition forces at the Corps and below levels."

Page 51, footnote 16: last organization should be Military Medical Institute, not National Medical Institute (Kabul).

Page 74, first paragraph: DOD IG had an office call with HQ ISAF CJMED but this was not mentioned.

Page 79, at the top: underneath the word Afghanistan, delete USFOR-A and add bullet for HQ ISAF CJMED.

The Assistant Secretary of Defense for Health Affairs

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

May 6, 2011

MEMORANDUM FOR INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE

SUBJECT: Department of Defense Inspector General Draft Report, "Assessment of U.S. Department of Defense Efforts to Develop an Effective Medical Logistics System within the Afghan National Security Forces," (Project No. D2011-D00SPO-0092.000)

The Office of the Assistant Secretary of Defense (Health Affairs) has reviewed the draft report of the Department of Defense Office of the Inspector General, titled "Assessment of U.S. Department of Defense Efforts to Develop an Effective Medical Logistics System within the Afghan National Security Forces."

Thank you for the opportunity to review the report and provide comments. My specific response to the report's conclusions and recommendations is attached. The points of contact for this matter are Dr. Warner Anderson (Functional) and Mr. Gunther Zimmerman (Audit Liaison). Dr. Anderson may be reached at (703) 824-4310, and Mr. Zimmerman may be reached at (703) 681-4360.

Jonathan Woodson, M.D.

Attachment:
As stated

DoD IG DRAFT REPORT
D2011-D00SPO-0092.000

"Assessment of U.S. Department of Defense Efforts to Develop an Effective Medical Logistics System within the Afghan National Security Forces"

RESPONSE TO THE RECOMMENDATIONS

RECOMMENDATION #17b. Under Secretary of Defense for Personnel and Readiness designate a reach-back partner institution for the Afghan Armed Forces Academy of Medical Sciences to include the "Research-to-Policy-to-Doctrine-to-Training-to-Execution" chain guidance.

DoD RESPONSE: We agree with the recommendation as written. Assignment of a reach-back partner institution should take into account other issues raised within the report, namely the primacy of Army medical support doctrine in the development of the Afghan National Security Forces medical support capability. The designated organization should be appropriately funded for this new task, potentially with non-Defense Health Program (DHP) funds, due to the legal restrictions concerning the DHP.

RECOMMENDATION #19a. Under Secretary of Defense for Personnel and Readiness designate the AMEDD Center and School or similar institution to be the Center of Excellence for Medical Training Advisory Group pre-deployment training with an approved program of instruction that is tailored for the mission in Afghanistan.

DoD RESPONSE: We concur with the recommendation as written. The designation by USD(P&R) of a service institution to be a, "Center of Excellence for Medical Training Advisory Group pre-deployment training," is a necessary first step to ensure fully trained and qualified service members fill the senior policy development mentoring positions with the Afghan National Security Forces. Additional efforts are needed to identify the unique aspects and expectations required for a successful medical mentoring program. These should be the basis of the measures of effectiveness that will be used to develop the appropriate training needed for pre-deployment and well as in-country training. An excellent starting point to develop this training is the Medical Stability Operations Course, developed by the Defense Medical Readiness Training Institute. It focuses on the medical aspects of stability operations to include working with the Interagency partners and consideration of host nation language, culture and beliefs. It will cover many of the issues identified in the report.

Special Plans & Operations

Provide assessment oversight that addresses priority national security objectives to facilitate informed, timely decision-making by senior leaders of the DOD and the U.S. Congress.

General Information

Forward questions or comments concerning this assessment and report and other activities conducted by the Office of Special Plans & Operations to spo@dodig.mil

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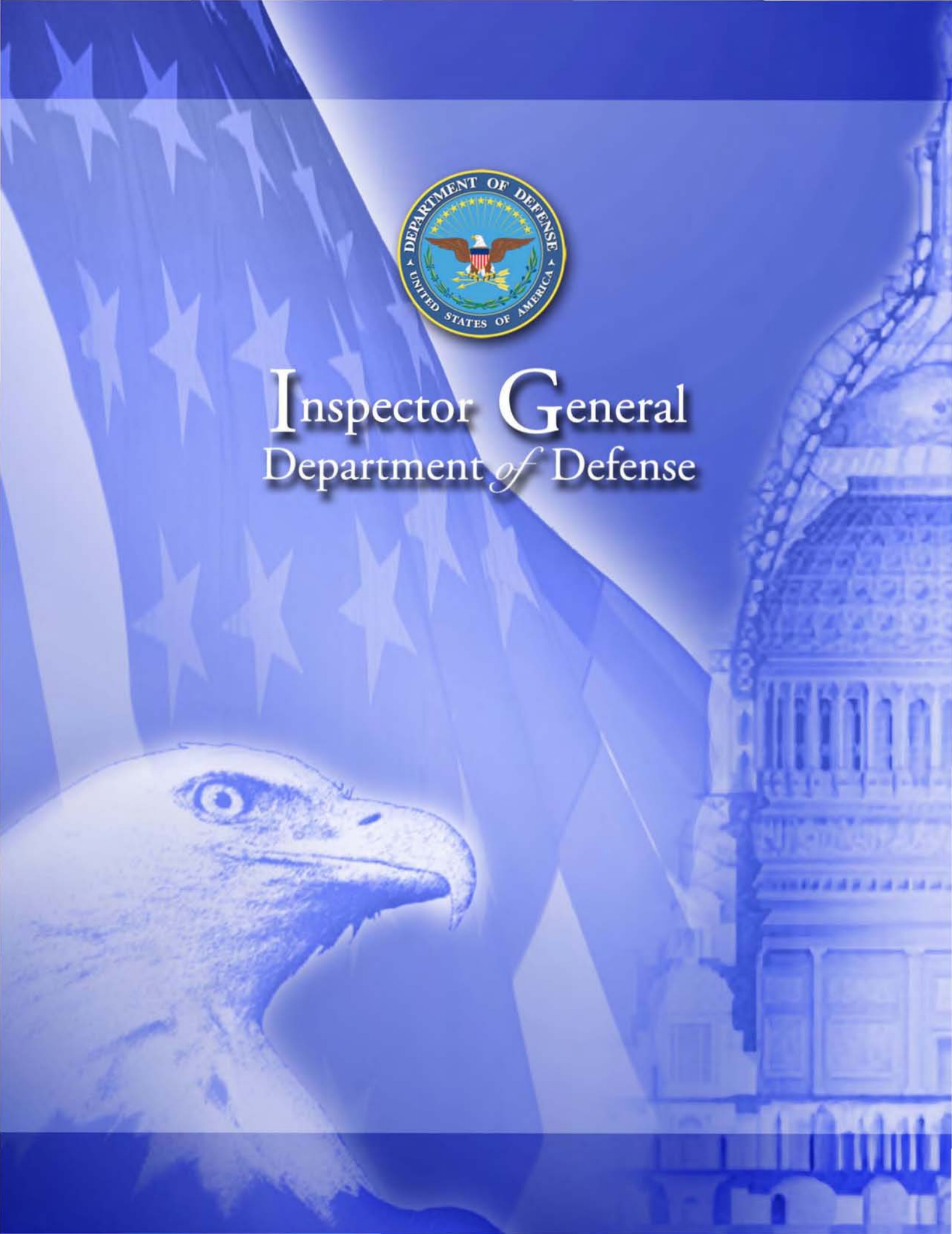

Inspector General
Department of Defense